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ABSTRACT

Designed to explore the organization of international programs providing service to voluntary and governmental agencies which aid the disabled, the International Research Development Project analyzed current patterns of organizing rehabilitation services, methods of training personnel, barriers to communication and understanding, and methods of disseminating research information. Through examination of such sources as the International Project Information Service, the International Research Referral Service, the Eleventh World Conference, and the Multilingual Rehabilitation Terminology References, the Project attempted to evaluate the international need for improved rehabilitation services in both economically developed and developing areas. It was recognized that multidisciplinary cooperation in the international rehabilitation field is too complex to formulate static conclusions; therefore, the results of the study indicated a variety of procedures and broad areas for further study. Appendixes present additional data including reports on rehabilitation services in the Philippines and Nigeria, and information on selected conference participants. (BD)

Final Report on
International Research Development Project
RD 2293-G. 1966-1969

ED044840

Planning for The Decade of Rehabilitation 1970-1980

New Patterns of International Service

EC 030 588

International Society for Rehabilitation of the Disabled
219 East 44th St., New York, N.Y. 10017

SIGNIFICANT FINDINGS FOR REHABILITATION WORKERS

1. In organizing for meaningful international cooperation it is necessary to be certain there is a potential for genuinely valuable activity. Once the validity of the program objectives has been established, an organizational structure must be evolved which will make maximum use of contributed professional talent and at the same time provide a workable administrative mechanism.

2. In order to plan effectively and economically, international organizations have a need for validated data identifying the existing services and relevant needs of the countries and individuals which they serve. Such information can be provided by an international organization using its worldwide communications network and can be used for cooperative long-range planning, particularly by organizations offering technical assistance.

3. A need exists for a service providing, on an international basis, information about ongoing research in the rehabilitation field. Such a service helps to reduce duplication of efforts and accelerates the practical application of research findings. Many investigators, however, are reluctant to publicize information about their research before completion.

4. If the needs and problems of disabled persons throughout the world are to be met now and in the future, new methods of training personnel and delivering services on a variety of levels must be sought. Basic and essential services to provide medical, educational, social and vocational assistance can be identified and patterns of training can be established to make use of available manpower.

5. Multidisciplinary world congresses offer participants a sense of identity with a common cause and provide opportunities for international contacts and exchange of information and experience. Their scientific and technical value is limited, however, by the necessity to arrange a program interesting to an audience composed of individuals and groups from a variety of professional disciplines, diverse cultures and varying levels of sophistication.

6. Communication between groups and between individuals is facilitated by different types of terminology manuals. Many rehabilitation disciplines have not arrived at standardized definitions of key terms which impedes communication on local, national and international levels.

7. New and innovative techniques in the organization and administration of rehabilitation programs must constantly be studied and experimented with if the needs of the disabled in a rapidly changing world are to be served.

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PLANNING FOR THE DECADE OF REHABILITATION: 1970-1980

NEW PATTERNS OF INTERNATIONAL SERVICE

Final Report of International Research Development Project
RD 2293-G, 1966-1969

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CHAPTER I -- INTRODUCTION

Statement of the Problem

A recent survey conducted by the Secretariat of the International Society for Rehabilitation of the Disabled has revealed some sobering estimates about the extent of disability and the availability of rehabilitation services throughout the world. It would appear that there are approximately 300,000,000 persons in the world who require some form of rehabilitation services and who cannot get help because it is not available where they live. Predictable factors of population growth and increase of disability suggest that a minimum of 3,000,000 disabled persons will be added to that total each year. In the industrially developed countries also, where governments and voluntary organizations have not yet succeeded in meeting the needs of their growing handicapped population, problems arise in effective communication, sharing of information derived from research and experience, and unnecessary and wasteful duplication of efforts.

The International Research Development Project was created to explore methods for meeting these international rehabilitation needs. Its original purpose was "to stimulate and encourage needed research in all fields of rehabilitation; to make the findings of current research available to all countries; and to explore ways of lessening the time lag between the completion of research and its practical application by studying the most effective means of transmitting information." In addition it was to explore optimum methods of developing rehabilitation services to serve as a pattern for other international organizations and for the governments of countries concerned with initiating or extending rehabilitation programs.

During the course of the three-year grant period it became evident that in order to achieve the objectives of the Project, a great amount of preliminary organization and fact-finding required to be done. It was during this period that the governing bodies of the International Society for Rehabilitation of the Disabled gave new direction to the activities of the organization. With the full agreement and cooperation of the Social and Rehabilitation Service, changes in the design and methodology of the Project were suggested without departing from the essential nature of the original objectives. These changes involved a preliminary assessment and understanding of the rehabilitation needs in both the economically developed and developing worlds and an exploration of the most effective organizational mechanism to meet those needs.

Background Information

The International Society is in a unique position to fulfill the purposes of the Project. It is the world's only major international organization concerned with all aspects of the problem of disability and with the measures for the solution of those problems. Its constituency includes laymen and volunteers as well as all professional disciplines and its activities extend to most countries of the world. Since its establishment in 1922 it has gradually developed its scope and program to the point where its influence is felt in more than 60 countries. The International Society for Rehabilitation of the Disabled has had a significant influence on initiating and strengthening rehabilitation services throughout the world through its program of consultations, international meetings, information services, publications and technical assistance, and has cooperated extensively in its activities with the United Nations and the Specialized Agencies and with the International Division of the Social and Rehabilitation Service of the United States Department of Health, Education, and Welfare. Serving as the Secretariat of the Council of World Organizations Interested in the Handicapped, the International Society for Rehabilitation of the Disabled also has maximum opportunity to exchange information with all the important non-governmental organizations active in the rehabilitation field.

The objectives of the International Research Development Project are closely allied with those of the International Program Development Project (RD2297) which the International Society has conducted concurrently. The purposes of that Project are briefly, to study, evaluate, improve and demonstrate methods of international communication which may assist in the improvement of rehabilitation services for the disabled in all countries. Through the network of communication channels set up by the International Program Development Project, including periodicals, publications, films, and information services, the information acquired by the International Research Development Project regarding rehabilitation concepts, practise procedures, and research, have been disseminated to appropriate government ministries, governmental and non-governmental organizations, and national and local bodies throughout the world.

Methodology

The International Society for Rehabilitation of the Disabled has undertaken a number of specific activities through the International Research Development Project to explore the scope of international rehabilitation problems and to suggest ways in which basic services

can be delivered to areas in which there is little, if any, trained personnel, where poverty and ignorance are constant factors and where governments, hard pressed by other problems, have accorded low priority to rehabilitation. In addition, other activities have been carried out under the Project to identify improved methods for enabling rehabilitation programs, institutions, and organizations in different parts of the world to share the wealth of experience and research that they have developed. The organization of international rehabilitation programs, the efficacy and value of international rehabilitation meetings, the approaches to formulating a satisfactory rehabilitation nomenclature directed towards a standardized terminology and methods of informing researchers in all countries of the ongoing work of their counterparts have been studied. The following activities encompass the essential aspects of the Project:

Organization of International Programs. Traditionally the research and program activities of the International Society have been carried on through a number of special interest groups. At the beginning of the project period, thirteen of these were in existence with the following fields of interest: arthritis, cerebral palsy, speech and hearing, spinal cord injury, special education, vocational rehabilitation, leprosy, volunteers, films, social aspects, technical aids, prosthetics and orthotics. An "umbrella" commission, the World Commission on Research in Rehabilitation was empowered to coordinate the research functions of the other groups.

The division into special interest groups has resulted in a variety of experiences and differing degrees of success and failure in the utilization of research and programming data from various parts of the world. The International Society undertook an intensive analysis of its experience with this programming structure to determine if it was an efficient and effective mechanism for international organizations such as itself which serve as the focal point for worldwide activity in a broad field and endeavor to stimulate and assist the development of services within a particular area of concern.

An International Conference on the Organization of International Programs was convened in Belgium under the auspices of the Project as a part of the analysis. It enabled the experts affiliated with the International Society who have had major and direct involvement in its program activities to consult collectively. As a result of the Conference and the preliminary analyses prepared for the Society's Executive Committee, many significant recommendations regarding program structure modification were developed which would be of benefit to a variety of international organizations. These recommendations and the findings from which they were derived are presented in Chapter II.

Project Information Service. In order to bring about an effective and rapid delivery of rehabilitation services it was essential to learn what services already exist in any given country. Investigations carried out with the responsible officials of the United Nations, WHO, ILO, UNESCO and a number of non-governmental and voluntary agencies, established a priority need for the improved collection and utilization of information concerning international activities being carried out to assist programs for the disabled.

There have been loose means of coordination such as the biennial Ad Hoc Inter-Agency Meetings of the UN family, the Council of World Organizations Interested in the Handicapped and various ad hoc contacts among the interested parties, none of which has met the real need for reliable and comprehensive information about past and present projects and future plans. All the agencies contacted, including the International Division of the Social and Rehabilitation Service, expressed a keen interest in and a profound need for a project information service which would assemble, maintain and make available such information. Under the auspices of the International Research Develop Project, methods of operating such a service have been examined and are described in detail in Chapter III.

Research Referral Service. The International Research Referral Service, which was initiated in 1965 by the World Commission on Research in Rehabilitation and has been strengthened under the auspices of the current grant, serves as one of the Project activities which most directly strengthens the lines of communication between researchers. The Research Referral Service endeavors to keep researchers around the world informed of ongoing projects thereby enabling them to be in touch with their colleagues in other countries. Various approaches have been used to stimulate greater participation in the Referral Service among individuals and organizations directly engaged in rehabilitation-related research activities in order to enhance the Service's ability to lessen duplication of similar research efforts. The results of these explorations are described in Chapter IV.

Assessment of Levels of Service Related to Available Resources. In essence, the primary function of the International Society for Rehabilitation of the Disabled is to expedite the delivery of rehabilitation services to handicappped individuals where and when they are needed. While progress has been achieved in initiating and improving rehabilitation services in the newly developing countries, it remains true that existing services are grossly inadequate when compared with the number of persons requiring help. Furthermore, it may reasonably be projected that the number of persons requiring

rehabilitation services will greatly increase in the future, especially in the now developing areas. It is likely that the ratio of services to persons requiring them will become progressively less favorable in underdeveloped areas of high population if the current methods and tempo of development are maintained.

With this in mind the International Research Development Project sought to make an objective analysis of the current methods in use by inter-governmental, non-governmental, and national agencies to effect the delivery of services. To do this, a number of experts representing international organizations and a carefully selected group of individuals native to several developing countries and with broad experience in the rehabilitation field, were convened for a conference to assess the levels of service related to available resources. Their discussions, conclusions and recommendations offer guidelines for international and national bodies which have confronted the overwhelming problems of attempting to relate the sophisticated methods and standards of rehabilitation in North America and Western Europe to the economies and cultures of Asia, Africa and Latin America. A report of the meeting is included in Chapter V.

World Congress. One of the mechanisms for exchanging information about rehabilitation and research is the World Congress. Triennial international meetings have been held by the International Society since 1951. At each Congress approximately 2,000 professionals and laymen actively interested in every conceivable phase of rehabilitation and representing almost every country in the world participate in a complex technical and social program designed by the organizers to give them quantitative exposure to research, programs, films, exhibits and personal contacts. Under the auspices of the International Research Development Project, a study was made of the ISRD's Eleventh World Congress held in Dublin in September 1969, to determine whether a large international meeting with a general program orientation is an effective medium for furthering worldwide development of rehabilitation activities. The Congress evaluation is presented in Chapter VI.

Terminology. The language of rehabilitation is not universal. Rehabilitation planners and practitioners have been harassed by the verbal and written barriers to communication since rehabilitation concepts were first advanced. The problems, of course, are not confined to the rehabilitation world, nor are they exclusively international problems. Communication difficulties exist between professionals speaking the same basic language, between practitioners and patient and certainly between researchers engaged in technical and scientific research.

The International Society for Rehabilitation of the Disabled has long been aware of the need for a standard nomenclature and terminology in rehabilitation and has in the past contributed to a solution of the problem by assisting in the preparation of a number of references.*

It was evident that a more unified approach to the problem was necessary and a meeting on terminology was convened at the Eleventh World Congress in Ireland, September 1969. As a result of the interest generated at this meeting, it was decided to make a study, under the auspices of the International Research Development Project, of the many approaches to standardizing terminology and an extensive survey of the literature in this field. The study is described in detail in Chapter VII.

Aside from improving methods for developing rehabilitation services in all parts of the world and increasing the exchange of experience in the rehabilitation field, it is hoped that the results of these explorations will be of value to the administrators of rehabilitation services in the United States where similar problems of delivery of service and communication exist.

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* International Society for Rehabilitation of the Disabled. Glossary of Terms Commonly Used in Vocational Rehabilitation in English, French, German, Spanish, and Portuguese. New York: ISRD, 1966. 6 pp.

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World Confederation for Physical Therapy. Glossary of Terms Commonly used by Physical Therapists in English, French, German and Spanish. London: WCPT, 1965. 15 pp.

CHAPTER II -- THE ORGANIZATION OF INTERNATIONAL PROGRAMS

As the major international agency working in the field of rehabilitation, the International Society for Rehabilitation of the Disabled has attempted to find a program structure which would utilize to its maximum benefit the professional talent and personal motivation of an international constituency, be administratively economical, constructive as regards program and serve as a model to other international agencies concerned with efficient and effective organization.

Program Structure Based on Committees and Commissions

International organizations, the ISRD among them, frequently use the committee structure to carry out program functions. Committees or commissions are established in response to specific needs and continue in existence with varying degrees of activity even though their original function may have been fulfilled or their initial objectives have changed. Since 1949, thirteen committees, commissions and boards have been established by the ISRD, dealing with many of the disabilities and most of the functional areas of rehabilitation. The following fields were covered: arthritis, cerebral palsy, speech and hearing, spinal cord injury, special education, social aspects, vocational rehabilitation, leprosy, films, volunteers, technical aids, housing and transportation, prosthetics and orthotics. In some cases and for a variety of reasons which will be analyzed later, some committees established by the International Society flourished and have acquired considerable importance in the international rehabilitation field. Other committees have never attained a measurable level of either performance or importance.

Confronted with the desire and necessity to design a program structure which would serve effectively and efficiently the needs of the International Society and which, at the same time, might serve as a guide for other international organizations, the ISRD Executive Committee directed the Secretariat to undertake a careful and intensive analysis of the existing situation and future program needs.

Functions of the ISRD

An analysis of the constitutional functions of the ISRD and the optimum methods of implementing those functions is shown in Appendix C.

According to the Constitution of the ISRD, the organization is charged to:

1. Effect an international exchange of information

2. Organize international meetings

3. Encourage research

4. Encourage formation and development of organizations working for the disabled.

5. Assist in development of programs for the disabled.

6. Cooperate with other international organizations.

7. Stimulate and assist in development of suitable legislation.

8. Provide international services and technical assistance.

The general objectives of the ISRD include:

1. Provision of an international institution which will symbolize, defend and represent the best interests of the world-wide rehabilitation fraternity, including the disabled, the professional workers and the volunteer participants.

2. Provision of an international focal point for the participation and affiliation of organizations and individuals interested in this field and to give them opportunities for international activity and identity.

3. Elimination, when appropriate, of the need for a proliferation of special interest groups and provision, as possible, of channels for coordinated efforts among all interested organizations.

Having examined the program needs of the International Society, the Secretariat then undertook an examination and analysis of the committee/commission structute, the part which it has played in the development of the organization and the problems which it has engendered. (See Appendix B).

The analysis indicated:

1. No appreciable distinction exists between the definitions of "committee" and "commission."

2. Committees/commissions are established by and are responsible to governing bodies of the ISRD. They are an integral part of the structure of the ISRD and their program, finance and other functions are the responsibility of the governing bodies of the ISRD, implemented by the Secretary General. The above prinicples have not always been observed in the operation of committees/commissions.

3. The problem of adequate communications which beset most international organizations, has contributed strongly to most of the other obstacles to the effective operation of committees/commissions.

4. There had been an absence of agreed procedure for the establishment of ISRD policy on the questions of substance dealt with by committees/commissions and no arrangements for the coordination of policy action among the various committees/commissions or between them, the Secretariat and the governing bodies. As a consequence there have been occasions when the officers of a committee or commission have presented to official bodies a policy or policies which have never been considered by the governing bodies of the ISRD, or when the governing bodies have supported or expressed policy positions without previous consultation with the relevant committee or commission

5. No generally accepted procedure for coordinating the program activities of committees/commissions was indicated.

6. A direct relationship exists between the facilities for financing the work of committees/commissions and the nature of the subsequent activity. In the case of one Commission, the World Commission on Vocational Rehabilitation, which was adequately funded and staffed through Social and Rehabilitation grant monies, a measurable amount of activity and achievement was apparent. Plans formulated by the Commission were implemented by full time staff with primary responsibilities in their area and frequently were subsidized by grant funds.

The World Commission for Cerebral Palsy was also separately funded by annual contributions from member organizations. The degree of activity from the group was noticeably greater than that of committees/commissions without special funding.

7. The composition of the committees/commissions was frequently decided on a rather random basis. Conscious attempts were made to insure geographic representation, which sometimes resulted in less than genuine interest on the part of the member so selected. The membership of many committees/commissions assumed unwieldy proportions

because of a lack of selectivity in making appointments.

8. The administration of large membership lists created difficulties for a limited staff which could better have been occupied in stimulating and implementing program activities.

9. Finally, analysis revealed that much of the program activity engaged in under the aegis of the committees/commissions was frequently the work of a few individuals rather than the result of combined and coordinated group planning.

Conference on the Organization of International Programs

In order to discuss and evaluate the problems and positive benefits posed by the committee/commission structure and to determine how the specific and general objectives of the ISRD could best be served, a Conference on the Organization of International Programs was convened in Brussels, Belgium, in April 1969. Chairmen (or representatives) of all committees/commissions met with members of the ISRD Executive Committee and invited consultants to present reports of their experience in working with their particular expert groups. Although a diversity of viewpoints was apparent, there was also concurrence on a number of significant factors. These included the following:

The problems inherent in international communication are an ever-present difficulty. Geographical distances, language barriers, lack of financing to support face-to-face discussion, limitations of Secretariat staff to expedite correspondence between members, all contributed to the feeling that no committee was a well organized, cohesive group.

Opportunities for meeting as groups were rare because of the geographical spread of membership and because travel funds could rarely be provided by the parent organization. As a result, coordinated planning and activity were virtually impossible and correspondence as a medium for exchange of ideas was usually unsatisfactory and unproductive.

It was also pointed out that the meeting had provided the first opportunity for chairmen of all committees to meet in joint session and to relate the functions of each group to that of the others. Evident in the operations of the committees has been a lack of

coordination and inadequate knowledge of the objectives of the other groups - resulting in duplication of efforts as well as in a failure to be effective because of ignorance of the overall needs. As a result of this lack of cohesiveness, members of the committees worked more as individuals than as groups.

Advantages and Disadvantages of Special Interest Groups

A brief resume of the comments of the chairmen or representatives of each committee reflects their ideas as to solutions for more effective and efficient functioning and/or a greater contribution to the total program effort of the International Society.

Advisory Committee on Arthritis. Consultants or advisors could perform the same function as a committee. These advisors should be recruited from geographical areas and should include representatives from the medical and the social or voluntary fields.

World Commission for Cerebral Palsy. The Commission desired a degree of independence not consistent with the policies and practices of the ISRD, in selecting members, initiating projects and raising funds.

Film Board. Two or three advisors to the Secretariat and to the other Committees could function in lieu of a Board.

Committee on Leprosy Rehabilitation. Since the integration of leprosy rehabilitation services into comprehensive rehabilitation programs is a desirable factor, there is no need for a Committee dealing with leprosy alone. Regional advisors to the Secretary General would be more effective.

Committee on Prosthetics and Orthotics. The Committee is financed mainly by sources other than the ISRD. Additional funding is provided by the ISRD through a grant from the United States Government. The Committee's active program of training courses and seminars must continue. If the Committee is to function effectively it must be permitted independent planning and action.

Commission on Research in Rehabilitation. The Commission's initial role as a stimulator of research has been fulfilled and it requested dissolution, believing that research should become the responsibility of each expert group.

Committee on Social Aspects of Rehabilitation. While it was emphasized that social research is essential to successful rehabilitation, it was felt that the function of this Committee had never

been clear. A diversity of disciplines are involved in social research. Because of the scientific nature of the research, the committee would function more effectively with trained professional staff rather than with a heterogeneous international volunteer membership.

Committee on Special Education. It was observed by the chairman that this group has a political flavor since its primary role is to consult with and influence governments as well as UNESCO and its national committees. It would function more effectively with a budget, a secretariat and with membership recruited from every nation affiliated with the ISRD. The Committee does not function as an information or training center.

Committee on Speech and Hearing. Because there are now four international speech and hearing organizations, the value and function of the group are uncertain. It's most important role should be as internal advisor to the other ISRD Committees.

Committee on Technical Aids, Housing and Transportation. The existence and activities of this group are now integrated with and partly supported by the Swedish Institute for the Handicapped, which was established in 1968. While the Committee performs an international service, its operation is relatively independent and not under the control of the Secretariat.

Commisssion on Vocational Rehabilitation. The chairman expressed a need for stronger cooperation with other Committees of the ISRD, as well as a need for regional sub-committees.

Volunteer Service Board. No accepted procedures have ever been adopted by this group, or established by the Secretariat. Consultants or advisors could function as effectively as an organized group.

Analysis of Program Function

In the earlier days of the rehabilitation movement there was validity in the formation of special interest groups in order to focus professional and public attention on the problems and needs of specific disabilities--such as cerebral palsy, arthritis, leprosy, etc. As rehabilitation concepts and programs have developed over the years it has become apparent that separate treatment centers for different disabilities lead to uneconomical use of valuable facilities and ever-scarce personnel, and are usually unnecessary. The enlightened trend, therefore, has been towards the integration of services for different disabilities into comprehensive programs for medicine.

education and vocational rehabilitation, with the social and psychological sciences providing information for and stimulating interaction among the rehabilitative disciplines. Dr. Itoh, in his analysis of the ISRD's Committee on Leprosy Rehabilitation (see Appendix A) says, "It should be the aim of leprosy work to lose identity among the infinitely greater volume of general medicine, general rehabilitation and general publicity.....The present limited resources should be used to the greatest advantage in inducing this change or merger."

The proliferation of special interest groups tends to make more difficult the coordination of progress among professions and partisans of specific disability groups. It is probable that generalized groups, if sufficiently aware of the needs of special interest groups, can provide a suitable mechanism for such coordination of planning and effort.

In reality the main activity of most of the ISRD committees/ commissions as they had evolved over the years, was the organization of seminars or program meetings usually in conjunction with the World Congress of the ISRD. This activity, of paramount importance to the special interest groups, can be continued under the aegis of a multidisciplinary organization sensitive both to their needs and to the timeliness of various problem areas.

Realizing that different disabilities are not restricted to any disease entity, that the child with cerebral palsy may also have speech and hearing problems; that hand surgery for arthritis is similar to that for leprosy, the Conference group considered a plan of merging interests into the major rehabilitation fields.

An analysis of the committees' functions as they have developed over the years indicated that they fall into four generic groupings:

1. Organic or functional committees. Groups whose skills are relevant to the total needs of the entire handicapped population. In this category are the following:

Committee on Social Aspects of Rehabilitation
Committee on Special Education
Committee on Vocational Rehabilitation
Committee on Research in Rehabilitation

2. Diagnostic or disability committees. Those which relate to a specific disease or handicapping condition.

Committee on Arthritis
Committee on Leprosy Rehabilitation
Commission for Cerebral Palsy

Committee on Spinal Cord Injury
Committee on Speech and Hearing

3. Advisory Committees. Those groups whose members as individuals are called upon to render occasional and specific service to the Secretariat.

Film Board
Volunteer Service Board

4. Information Centers. Those groups with separate secretariats which render direct service to professionals through seminars, publications and consultation.

Committee on Prosthetics and Orthotics
Committee on Technical Aids

(It is apparent, of course, that there is considerable overlapping within these generic groups, i.e., the Advisory Committees and Information Centers are potential sources of service for all groups).

Revised Structure

In organizing for meaningful international cooperation it is necessary to be certain there is a potential for genuinely valuable activity. While it is important for international organizations to provide meeting opportunities for individuals with special interests, such meetings do not necessarily advance program or result in planned long-range activity. The impulse to meet with one's colleagues and to join an international organization which provides suitable opportunities for reunion is strong and reflects a need of both individuals and institutions to identify with those of similar interests. However, unless there are adequate resources for an active secretariat and program, real accomplishment will frequently be minimal--a fact often obscured by the personal gratification gained by the individuals who participate in the group experience.

While recognizing that the committee/commission structure can contribute to the development and growth of an international organization, and in the case of the ISRD has done so, it was necessary to realize that the proliferation of committees/commissions, and the expansion and complications of their membership have created problems outweighing the constructive results. Communication, always a problem for international organizations, and limited financial resources, pose growing difficulties for international organizations as the number of groups increase.

As a result of the discussions held at the Conference on the Organization of International Programs, the governing bodies of the ISRD decided upon a reorganization of program interests into four Standing Commissions on the major fields involved in the rehabilitation process, initially the medical, educational, vocational and social aspects. The functions of the Standing Commissions are to advise the governing body (Council) of the organization, and the Secretariat on policies and programs in their fields of interest and to assist in the implementation of activities agreed upon by the Council. Each major Commission was to consist of individuals representative both of geographic areas and of relevant disciplines. Initially, a "working party" was to be appointed for each commission to draft suggested activities in each field for the consideration of the Council and to make recommendations for the full composition of each commission. It was believed that the program functions of most of the previous committees/commissions could be absorbed by the newly established Standing Commissions and, when appropriate and possible, representatives of the specific interest groups would be invited to serve on the appropriate commission. Opportunities would also be provided for seminars, workshops, etc. for special interest groups.

It was also recognized that certain national institutions have been created to provide information and other services on an international scale and that these have been developed under the umbrella of the ISRD committee/commission system. Specifically these are the International Committee on Prosthetics and Orthotics, receiving financial assistance from the government of Denmark, and the International Committee on Technical Aids, Housing and Transportation, heavily subsidized by the government of Sweden. While these international groups provide an important national function, they are nominally associated with the ISRD while maintaining a partly autonomous status. It was agreed that the important service functions of these two groups should be recognized and maintained. Although functioning independently, they would provide needed services to the ISRD and to other international and national organizations on a fee basis.

Conclusion

The organization of an agency responsible for initiating, strengthening and coordinating rehabilitation services on a worldwide basis must of necessity be affected by the size and complexity of its program, its resources of funds and personnel and its ability to mobilize and motivate voluntary manpower. Fragmentation of its program into a variety of special interest groups has resulted, for the International Society, in a complicated organizational pattern, difficult to administer, overlapping in function and frequently unwittingly calculated to lose the interest of the very people whose skills it has attempted to utilize.

CHAPTER III - INTERNATIONAL PROJECT INFORMATION SERVICE

Purpose

The International Project Information Service consists of a central file of data on all rehabilitation projects being carried out, implemented, or planned internationally, particularly with the assistance of international organizations. Its purpose is to provide qualified organizations with information that will assist them in planning assistance programs, evaluating requests for aid, and coordinating their activities with other ongoing projects. The Service was created in response to the need for comprehensive information about existing rehabilitation resources expressed by many of the inter-governmental, international, and national groups active in the international rehabilitation field.

Organizations and individuals responsible for initiating and developing rehabilitation programs throughout the world have, on many occasions, reaffirmed the importance of basing rehabilitation service planning on valid and comprehensive information about rehabilitation, medical, social, vocational, educational, and ecomomic resources available in particular countries and regions. This is especially true in those developing areas of the world where material and trained manpower resources are severely limited. At the International Labor Organization Regional Seminar and Training Course in Vocational Rehabilitation of the Disabled, Denmark, 14 July - 2 August 1969, which was specially designed for participants from African nations, it was concluded that:

> "It is essential in African countries to make the fullest possible use of limited resources and trained personnel in rehabilitation programmes for the disabled. This can only be achieved through the closest possible coordination at the local, national and regional levels of all existing medical, social, educational, and vocational services."

Similarly, at the Meeting of Experts on "Assessment of Levels of Service Related to Available Resources," Killarney, Ireland, September 21-24, 1969, sponsored by the ISRD (see Chapter V) it was agreed that:

> "At the earliest possible stage comprehensive planning should be undertaken to identify the most basic needs of the country. It should be based on the best available information as to the causes, incidence, and types of disability, methods of preventing the problems, and means of helping the victims to develop independence in daily living and gainful employment consistent with the resources available in the country."

The importance of coordinated action among all agencies concerned with the development of rehabilitation services in a particular area, whether these agencies function on an international, national, or local level, has also been emphasized. The World Health Organization Expert Committee on Medical Rehabilitation concluded that:

> "The need for rehabilitation services will increase very rapidly in the near future as a consequence of the development of basic health services, the integration of medical care in national health programmes, industrialization, and urbanization, and lengthening expectation of life. With the steady rise in the number of victims of industrial and traffic accidents and the aged sick, it is to be expected that more and more disabled persons will seek rehabilitation as soon as services are made available.
>
> When a government requests assistance with a specific type of rehabilitation activity, it is desirable to consider such action in relation to other rehabilitation needs, and if possible to arrange a coordinated programme between non-governmental organizations, inter-governmental agencies, and voluntary bodies."

and made the following recommendation for future action:

> "All governmental and voluntary bodies concerned should make a coordinated approach to the various aspects of rehabilitation."

Much the same idea was stated during the International Labor Organization Inter-regional Study Tour on Vocational Rehabilitation of the Disabled, held previously in 1967:

> "The essence of modern rehabilitation consists in the coordination of all who are concerned with the various aspects of rehabilitation. Such coordination is necessary amongst the government departments dealing with the problems of the disabled; between the government and voluntary agencies and associations formed by disabled persons themselves; and between the respective members of a rehabilitation team."

It is acknowledged that comprehensive information and coordinated efforts are fundamental to the development of rehabilitation services internationally, yet the number of organizations which are increasing their activities in this field without access to such information continues to rise. Numerous groups including professional societies specializing in rehabilitation-related fields, associations of disabled individuals with similar handicaps, international organizations for specific disabilities, coordinating bodies, national institutions, and inter-governmental agencies, have extended their rehabilitation programs

internationally. These diverse groups make important contributions to the improvement of services for the disabled through their information services, meetings, consultations, and other technical assistance activities. It cannot be doubted that their combined support is welcome and urgently needed to lift the level of rehabilitation services beyond the minimal level prevalent in most areas of the world.

However, the importance of channeling these diverse kinds of support into rehabilitation programs of the highest priority cannot be ignored. Only as essential rehabilitation services are strenghtened and demonstrate tangible results can further support be generated for the development of rehabilitation activities. In most instances, the success of initial programs is critical to future demands for additional rehabilitation services. The comprehensive information about rehabilitation resources made available through the International Project Information Service can assist in the assessment of rehabilitation needs in selected areas and can help to identify programs of the greatest urgency. Using such information, it is often possible to modify inappropriate assistance efforts, reduce duplication of efforts, and develop procedures better adapted to actual local conditions.

Previous Efforts

Previous efforts have been made to provide interested organizations with useful planning information. In 1964, 1959, and 1963, the United States Vocational Rehabilitation Administration compiled information regarding rehabilitation services in countries around the world in three publications: Rehabilitation of the Disabled in Fifty-One Countries, Rehabilitation of the Disabled in Thirty-Seven Countries of the World, Rehabilitation Programs and Facilities of Western Europe. The material gathered for the first two texts was compiled with the assistance of the United States Department of State through its embassies in the countries concerned. A research fellow collected the information for Rehabilitation in Western Europe through a series of site visits. These volumes provided valuable information for students, travelers, and international technical assistance organizations. It has not been possible for the Social and Rehabilitation Service to continue the enormous task of keeping this information up-to-date in published form.

A number of other references produced with support from the International Research Development Project and previous grant supported projects have also been of value. Under the auspices of the Project Drs. Wallace and Isabel Taylor conducted a study of Services for Handicapped Youth in England and Wales in 1967. This study was a detailed exploration of the broader survey on Special Education of Physically Handicapped Children in Western Europe which they conducted in 1960 with support from several voluntary organizations.

Other consultant surveys which have provided important information about international rehabilitation programs include: A Study of Rehabilitation Needs in West Africa by Miss M.J. Neilson, Secretary General of the World Confederation for Physical Therapy supported in part by the Research Development Project and Rehabilitation Facilities in East and South East Asia by Miss Jean Garside, ISRD Regional Assistant for the East, South-East Asia and Pan-Pacific area.

In addition, the United Nations and its specialized agencies and invited representatives of non-governmental organizations meet biennially in an Ad Hoc Inter-Agency Meeting on Rehabilitation to coordinate their activities in this field. The United Nations Rehabilitation Unit publishes and distributes a Summary of Information on Projects and Activities in the Field of Rehabilitation of the Disabled annually, to increase the exchange of information about current activities. Further coordination has been achieved through the Council of World Organizations Interested in the Handicapped and various ad hoc contacts among interested parties.

While all of these publications and meetings identify certain aspects of past and current international rehabilitation efforts none of them offer the comprehensive base for planning which the International Project Information Service endeavors to provide.

Method of Operation

Information is collected for the Project Information Service from a wide array of published and unpublished materials dealing with rehabilitation to insure a breadth of opinion and a multi-disciplinary evaluative approach that would not otherwise be possible. Proceedings of conferences, reports of consultant missions, periodicals, association reports, and directories are all scanned for relevant information. Current information is also derived from the correspondence and multiplicity of contacts which the ISRD routinely maintains with member organizations, non-governmental organizations, and inter-governmental agencies.

All information is then analyzed and classified according to nation, region, type of rehabilitation service, and extent of rehabilitation service, to give as complete a picture as possible of rehabilitation facilities in a given area. Relevant background information about prevailing economic, cultural and social conditions in areas under study is collected to guide the assessment of rehabilitation development potential. All available material is then compiled into a draft report about rehabilitation services in a selected country which is circulated to

local personnel and international organizations for verification and revision. The validated reports may then be made available to qualified institutions and organizations for their use. Separate appendices which include confidential evaluations of facilities and listings of key personnel are prepared for restricted use.

Preliminary Reports

Because the needs of the developing countries are paramount and since comparatively little information is presently available about the actual state of rehabilitation services in these areas, countries in Asia, Africa, and Latin America were chosen for study in the initial reports compiled within the International Project Information Service. The reporting form which was developed is illustrated in the sample reports on rehabilitation services in the Philippines and Nigeria contained in Appendices E and D respectively. The findings of these two reports exemplify how the scope and depth of rehabilitation needs in specific areas become apparent when comprehensive information is available. Brief summaries of the findings are as follows:

Nigeria--one of the most advanced and progressive of the newly developing African countries--has a population of approximately 57 1/2 million people. Prior to the civil war, there was one physician for each 31,700 people. Rehabilitation facilities are centered in Lagos and Ibadan and very little in the way of rehabilitation services are offered in any other part of this country which covers an area approximately 1/10 the size of the United States. While the Nigerian Government gives financial support to a number of facilities and centers, many of the efforts are from the private sector. A large proportion of these receive or have received assistance from international non-governmental agencies, and occasionally from experts requested by the Nigerian government and supplied by the United Nations or its Specialized Agencies.

There is a severe shortage of rehabilitation facilities for all types of disabilities in Nigeria. Considerably less than one-half of one percent of the estimated handicapped population has received some type of service yet reports indicate that even those few facilities available are not used to capacity. The paucity of trained personnel, particularly in rehabilitation-related fields other than physical therapy,and the almost complete lack of training facilities within the country may be contributing both to the shortage of rehabilitation facilities and the incomplete utilization of existing facilities. The bulk of the population does not lie within the Western region of the country in which the majority of existing rehabilitation facilities are located and no research has been initiated into the extent and

etiology of various prevalent disabling conditions. There has been no attempt to coordinate the work for the handicapped nor to pool the limited resources of trained personnel, funds, and physical facilities in the country.

International assistance has been sporadic and given with no comprehensive or long range planning in view. It is hoped that after a certain amount of post-war stability is restored to the country, the government will entertain and implement a proposal for a comprehensive rehabilitation planning scheme which has been submitted to the appropriate government ministries. If agreement is reached, the United Nation's Rehabilitation Unit, WHO, ILO, UNICEF, UNESCO, and interested non-governmental rehabilitation organizations would participate in such a cooperative plan of assistance.

The Philippines --has a population of thirty-five million people and it is estimated that one and three-quarter million of these people are in some way disabled. The majority of available rehabilitation programs are concerned with the orthopedically and/or neurologically handicapped and approximately 10% of the disabled in these groups have been assisted at some time. Leprosy patients may receive some rehabilitation services as a part of the leprosy control activities being extended to almost 75% of the affected population in this group. Less than 1% of all the blind, deaf, mentally ill, and mentally retarded people in the Philippines have received any type of rehabilitation service.

While the Philippine government has shown an interest in rehabilitation, it has not had the economic and professional resources to confront the problem in its entirety and make anything approaching adequate provisions for its disabled population. Voluntary efforts, although considerable, have also been insufficient. If existing rehabilitation facilities are fully used, approximately 50,000 people or 3% of the disabled population may receive some type of rehabilitation service. Since two-thirds of the major rehabilitation facilities are located in the urban areas of the island of Luzon, it can be assumed that only one-tenth of the national population which lives in this area has reasonable access to rehabilitation facilities.

The lack of trained personnel is a primary contributing factor to the shortage of rehabilitation services. While special training institutions are available for some categories of rehabilitation personnel, an insufficient number of workers are being trained to meet the needs of already existing facilities. The low salary scales for professional personnel have not been conducive to attracting people to the rehabilitation professions and, as a result, many of those people already trained and qualified prefer private practise, remain inactive

in their professions, or seek opportunities abroad.

There has been no lack of international assistance but although many intergovernmental bodies and international organizations have given substantial support to the creation and maintenance of programs, no concerted and cooperative attempt has been made to survey the entire situation and produce a comprehensive, long range plan taking the aforementioned gaps in service into consideration for the most effective utilization of existing resources and international aid.

Nigeria and the Philippines have many problems in providing rehabilitation services in common, including lack of trained personnel and concentration of existing facilities in urban areas serving only a small proportion of the total population. Yet the magnitude of their problems and the nature of existing facilities differ considerably. A tremendous need exists for increased international assistance to develop a basic level of rehabilitation services in Nigeria for all of the nation's disabled. In the Philippines, the need for extending rehabilitation services to rural areas and the importance of initiating services for groups other than the neurologically and orthopedically handicapped while improving the level of services for all categories of the disabled is apparent. The limited data presently classified within the International Project Information Service has helped to identify these needs for more effective technical assistance.

Future Development

The methods devised for the operation of the International Project Information Service have necessarily been exploratory in nature during this preliminary stage. As the Service is expanded, many of the procedures will warrant further examination and refinement. It is hoped that the following aspects of the Service may be considered further in the future:

---the collection of information for the Service in cooperation with concerned inter-governmental, international, and national agencies.

---the classification, organization, and storage of informational materials within the Service possibly using electronic and computer data techniques.

---the verification and revision of the reports and materials produced through the Service to most accurately reflect local conditions.

---the distribution of material produced through the Service to all interested organizations and institutions.

As adequate data become available, it may be possible to perform more general analyses and evaluations. Development trends and regional and global rehabilitation needs may be assessed. Information about successful and unsuccessful approaches to developing rehabilitation programs may also be derived from the data. The ISRD anticipates that it would be possible to mount a crash program for two to three years to obtain, process, verify and store sufficient information to reasonably cover available international rehabilitation resources. Maintenance of the material after the initial period would be a relatively smaller task and could be accomplished at any location as long as one central information storage area were maintained and standardized information collection procedures were instituted.

Expansion of the International Project Information Service in this manner should enable it to serve the needs of all national and international organizations interested in and contributing to the development of rehabilitation services for the disabled in all parts of the world.

CHAPTER IV - INTERNATIONAL RESEARCH REFERRAL SERVICE

While research in rehabilitation is still considered to be in an early stage, most of the techniques and procedures used in the rehabilitation process are due to the initiative of researchers and to the insights of imaginative individuals who have seen the relationship between the experience often gained in a seemingly unrelated field to areas of rehabilitation. The World Health Organization has emphasized the importance of basic rehabilitation research and has urged the appropriate organizations to seek solutions to the problems of the handicapped through concentrated research efforts.

In 1965, the ISRD's World Commission on Research in Rehabilitation (VRA Grant No. RD-536) established an International Research Referral Service designed to facilitate the exchange of information between researchers working in the same or similar rehabilitation related fields, so that duplication of efforts would be reduced and the practical application of research findings more rapidly achieved. Under the auspices of the International Research Development Project and with the cooperation of the U.S. Science Information Exchange, the Referral Service has been developed and strengthened with results which are satisfactory, although not yet sufficiently extensive.

Operation of the Service

Organizations supporting research and individuals engaged in research in all parts of the world are invited to participate in the Research Referral Service by completing brief summary forms describing their current or proposed projects. After these forms are returned to the International Society they are translated if necessary and are then forwarded to the U.S. Science Information Exchange for registration and coding. The Science Information Exchange regularly provides the Referral Service with current summaries of all registered projects related to rehabilitation which it has received from governmental and voluntary agencies within the United States. Project summaries judged to be of international interest are periodically duplicated and distributed to individuals and organizations interested in the particular areas of research covered by the various projects. More than one hundred different current summaries are generally distributed in each quarterly mailing of the Service so that information about approximately 1,000 planned or current research projects has been disseminated through the Service during the grant period

Research Categories Covered by the Service

The broad categories of research covered by the International Research Referral Service include: orthopedics, physical medicine,

neurological impairments, cardio-vascular disorders, prosthetics and orthotics, technical aids, speech and hearing, special education, vocational rehabilitation and psycho-social aspects. Each category includes finer divisions into specific disabilities, disease classifications, techniques and functions.

Circulation of the Service

In 1967, at the beginning of the grant period for the International Research Development Project, 45 individuals and organizations in 12 countries other than the United States requested and received summaries through the Research Referral Service. Recipients in the U.S. alone numbered 20. In addition, the summaries were sent to the member organizations of the ISRD and to the chairmen of the Society's Committees and Commissions.

During the project period (1967-1970), with the addition of a program specialist to the Project staff, it was possible to give more time and attention to developing the Service. As a result, in December 1969 the Service reached 258 organizations and individuals in 42 countries other than the United States. Approximately 30% of these recipients, or 76 researchers, received support for their projects from the International Research Division of the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. In increasing the circulation of the Referral Service, introductory material was distributed to all recipients of these U.S. government grants whose areas of interest corresponded to subject areas included within the Service.

During this latter period 23 researchers, individuals, and organizations in the United States also received research project summaries through the Referral Service. As United States residents may receive summaries of current projects being conducted nationally directly from the Science Information Exchange, these recipients were only sent summaries of research in progress in other countries.

In addition, efforts were made to cooperate with other research exchanges in disseminating information. The Research Utilization Branch, Social and Rehabilitation Service, Department of Health, Education and Welfare, agreed to provide the Referral Service with its research "Briefs" for distribution. Each "Brief" contains a single page summary of the significant findings and implications of an important research project which has been recently completed. Most of the "Briefs" describe projects conducted in the United States. The Research Referral Service also cooperated with the International Research Information Service of the American Foundation for the Blind.

This information service stores and distributes extensive information about published research in the field of blindness. A most helpful procedure for cooperating with this Service in locating researchers overseas has been established.

Promotion of the Service

As in the past, each issue of the International Society's quarterly periodical, the International Rehabilitation Review, carries an item of information about the availability of the Research Referral Service. As an added feature, a page of research project descriptions derived from the summaries available through the Service has been included. The type of project and its country of location are noted to illustrate the kinds of rehabilitation-related projects in progress. Those individuals desiring further information about specific projects are requested to write to the ISRD Secretariat for summaries and other relevant material. A number of individuals and researchers in approximately ten countries have responded to the initial coverage of research information in the International Rehabilitation Review, and it is expected that in time, further interest will be generated among researchers.

Effectiveness of the Service

Information has been collected from a number of sources for a preliminary assessment of the effectiveness of the Research Referral Service. In an initial attempt to assess its value, a short questionnaire was distributed to 42 of the original recipients in 11 countries. A 40% return was elicited. The 16 recipients in 6 countries responding to the form all indicated their interest in continuing to receive the Referral Service and generally reported utilizing the summaries for reference purposes. Other recipients have indicated their interest by submitting summaries of their current projects for distribution through the Service. Approximately 24 researchers in 13 countries, or about 8% of the recipients, contributed a total of 39 new project summaries in 1969. In addition, 65 other individuals and organizations throughout the world requested Referral Service materials in the same year. Within the past year, slightly less than 40% of all Referral Service recipients have indicated their interest in continuing to participate in the Service.

Experts in the field of rehabilitation research have also been consulted. These consultants have pointed out the critical need for information about ongoing projects during the planning stages of research projects. They have also noted that no other channel, aside from the Referral Service, exists for the exchange of this kind of information internationally on a continuing basis. Their main

criticism of the Service has been that the project summaries often do not reflect modifications in research design developed after submission of the summary even though these modifications may significantly alter the nature of the project in concern.

It has been difficult to obtain direct feed-back about the utility of the Referral Service, particularly during this expansion period. Letters have recently been sent to all recipients requesting suggestions for improvements. On the basis of their responses, a new questionnaire will be drafted for distribution at the end of 1970. In this way, we hope to more reliably determine which recipients find the Service to be of value and assess if the brief summaries are informative and of use in contacting other researchers directly. It is anticipated that this kind of survey will assist in identifying areas for future improvement within the Referral Service.

Conclusions

The urgent need for a mechanism to expedite the exchange of information between researchers has been continuously expressed by grant-making institutions in the United States and other countries. As one method of organizing services to benefit rehabilitation programs in the developed areas of the world, the Research Referral Service was initiated by the ISRD's World Commission on Research in Rehabilitation and developed and extended by the International Research Development Project.

The value of the Service lies in the fact that it reports information about research in the proposed and ongoing stages, not after the completion of the work. By enabling researchers to be in touch with each other, it is hoped that duplicating factors will be eliminated and that research in one country will be enriched and strengthened by the investigations in similar fields in other countries. The Service provides an important channel for the dissemination of information about rehabilitation-related research being conducted in developed countries to those developing areas of the world where rehabilitation efforts are just being initiated and researchers have only limited access to the professional publications, meetings, and conferences which deal with recent developments in their fields. The Service is also of reciprocal value to researchers in the developed areas as it exposes them to the variety of different approaches being developed to meet the challenge of rehabilitation research in developing countries.

Rehabilitation is mainly a clinical field and many of the most important advances in treatment and evaluation have been stimulated by research projects which depend more on observant clinicians and researchers than on complex methodology and techniques. The Research

Referral Service publicizes all types of rehabilitation research efforts, including those which rely least upon advanced technology. The Service demonstrates the fact that essential research may be conducted in the simplest circumstances and it is hoped that, as a result, rehabilitation workers may be stimulated to conceive research projects where none had been anticipated before.

Development of the Service has been gradual and has possibly been hampered by a desire on the part of some researchers to withold information about design and methodology prior to publication. Only a small percentage of recipients have actively supported the Referral Service and, in its present stage, it barely reflects the breadth of rehabilitation-related research being conducted internationally. Yet considerable interest has been shown in the Service and indications of the need for information about projects in progress have all been positive. The ISRD therefore plans to continue expansion of the Service under the International Communications Project during the period 1970-1972.

In the future, it will be important to reach greater numbers of researchers directly and increase the publicity about the availability of the Service. Greater cooperation with national and international research exchanges and grant-making organizations, including the International Division of the Social and Rehabilitation Service, United States Department of Health, Education and Welfare, should also be sought. An important source for the identification of potential recipients of the Referral Service is the International Project Information Service (see Chapter III) which will be expanded concurrently under the International Rehabilitation Service Development Project.

It is hoped that as additional steps are explored to broaden the Research Referral Service, researchers, institutions, and organizations will respond by increasing their support and make the Service of added value to all those concerned with rehabilitation research.

CHAPTER V - ASSESSMENT OF LEVELS OF SERVICE RELATED TO AVAILABLE RESOURCES

Aware that the problem of disability is growing more rapidly than are mankind's provisions to solve it, the ISRD under the auspices of the International Research Development Project decided to explore whether there were new or different approaches to the problem of developing rehabilitation services that might make it possible to speed up progress in this field. After consultations with a number of interested organizations, it was agreed to convene a small group of experts to examine the question and to determine what further steps might be taken.

The meeting was held in Killarney, Ireland, September 21 to 24, 1969. Participants included representatives of the United Nations, appropriate Specialized Agencies and Non-Governmental Organizations having experience, competence, and interest in the subject, and individual experts invited by the International Society for Rehabilitation of the Disabled because of their experience and competence.

Basis for Discussion

Participants were given the following background statement as a basis for the discussion:

> "While important progress has been achieved in initiating and improving rehabilitation services in the newly-developing countries, it remains true that existing services are grossly inadequate when compared with the number of persons requiring help. Furthermore, it may reasonably be projected that the number of persons requiring rehabilitation services will greatly increase in the future, especially in the now developing areas. It is likely that the ratio of services to persons requiring them will become progressively less favorable in under-developed areas of high population if the current methods and tempo of development are maintained.
>
> It is possible that an objective analysis of methods of delivering rehabilitation services will suggest measures which can serve to provide at least the most essential assistance to larger numbers of people with the resources available now or in the immediate future. The identification of such measures could have significant implications on the recruitment, training and employment of personnel in rehabilitation programs, on the organization of services, on the building and equipment required and on the budgets of the organizations concerned.

It is assumed that complete and comprehensive medical, social, educational and vocational services, staffed by individuals fully trained in accordance with the standards established by the competent bodies, is and will remain the optimum target. At the same time, however, it is possible that progress towards the ideal may be achieved through a series of stages, at each of which progressively more adequate services would be provided in accordance with the quality and quantity of available personnel and facilities.

Experience in the less developed areas makes it clear that essential help may be given to disabled persons in ways which are often different from those methods established for use in industrialized and economically developed areas but are consistent with the available resources and the cultural, social and educational patterns of the developing country. While it may be many years before methods and facilities appropriate for use in these areas will be developed fully enough to enable the needs of all handicapped persons to be competently handled, it may be possible to identify forms and patterns of service which, by requiring fewer trained personnel, less advanced levels of training, simple facilities, etc., may enable the delivery of essential services to be expedited and expanded.

Consideration of these possibilities must be a cautious and carefully planned process. It is essential to insure that the standards of training and performance established by the competent professional groups are respected. It is important to avoid giving opportunity for semi-trained individuals to claim the status of established professionals. It is necessary to plan so that the beginning and intermediate stages of service are viewed as interim phases in which services are being provided while the necessary preparations are being made for further progress."

Organization of the Meeting

The work of the meeting was carried out through discussions in plenary sessions and in specialized working groups, which drafted statements dealing with their particular areas of competence. The meeting as a whole considered all statements and, except where it is specifically indicated, there was consensus concerning the conclusions and recommendations presented. A series of general principles recommended for application in the development of rehabilitation services, especially in areas of limited resources, and a series of specific recommendations which contain information concerning the training of personnel and the initiation and improvement of primary

rehabilitation services were prepared.

Every effort has been made to use terminology which will be widely understood. It was the wish of the meeting that it be made clear that the following terms are used with the meanings indicated:

> Professional: "a worker trained to the generally accepted level for that discipline in a particular country." *
>
> Auxiliary: "a technical worker in a particular field with less than full professional qualifications." *
>
> Aide: "a person who may perform many routine, non-treatment duties in a rehabilitation department." **

This first, exploratory meeting has produced a number of generally agreed ideas that should suggest means of improving and expediting the development and delivery of rehabilitation services, especially in areas where resources for this purpose are limited. It is recognized that more detailed consideration must be given to some areas of the question than was possible in this brief and small meeting and that further analysis of the means of implementing the ideas agreed upon should be carried out. The ISRD will plan such additional studies and action, and will welcome similar initiatives from other organizations.

General Principles

The most important measures for the initiation or strengthening of national rehabilitation programs are:

a) The training of personnel to provide the required services.

b) The integration, through proper coordination and administration, of the developing services, both within themselves and with whatever relevant educational, medical, social and vocational services already exist in the community.

c) Action to inform and educate the public as to the problems of disability and the possibilities of rehabilitation.

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* WHO Technical Report Series number 212 "The Use and Training of Auxiliary Personnel in Medicine, Nursing, Midwifery and Sanitation."

** World Confederation for Physical Therapy "The Training of Physical Therapists", January, 1967.

Essential services can be provided with very simple buildings and equipment, and a high priority need not be given to the provision of elaborate physical facilities.

Especially in the developing countries, services designed primarily to assist children and young people to develop their ability to care for themselves and to take part in gainful employment should be established at the earliest possible stage.

Administration and Coordination. The importance of effective administration and coordination of services must be recognized. This applies alike to voluntary and governmental services and institutions, to those specifically initiated as a part of the rehabilitation program and to relationships among them and relevant existing services.

At the earliest possible stage, comprehensive planning should be undertaken to identify the most basic needs of the country. It should be based on the best available information as to the causes, incidence, and types of disability, methods of preventing the problems and means of helping the victims to develop independence in daily living and gainful employment consistent with the resources available in the country.

It is frequently necessary to make a specific effort to educate both the public and rehabilitation personnel themselves to understand the need for adequate administration and coordination.

When resources are limited, first priority should be given to programs and services that will give clear and significant results. When effective prevention of disease or other causes of disability is possible, that should be given highest priority, but services must also be planned and provided to assist those who have been disabled before prevention was effective.

Personnel. Where fully trained personnel with currently accepted qualifications are not available in sufficient numbers to cope with the problems, auxiliary personnel should be prepared through training in the institutions at which they work and through courses organized in the country or region. A progression of grades of auxiliaries may be established and, as far as possible, further training to reach full qualification should be encouraged. It is recognized that some auxiliaries in the lower grades may first be required to improve their basic education. An example of the use and progressive training of auxiliaries to work in connection with physical and occupational therapy is given in "Auxiliaries in Physical Therapy and Occupational Therapy."

There was not full agreement concerning the training and employment as auxiliaries of technicians in the fields of prosthetics and

orthotics. The currently generally accepted view about the training of such personnel is presented in "The Training and Employment of Technicians in Prosthetics and Orthotics." Experience using an alternate procedure is reported in the same section.

The possibilities of giving assistance to disabled persons in both rural communities and urban districts may often be improved by the use of a worker variously described as a "general rehabilitation auxiliary," "rehabilitation assistant," "community development assistant," or "village visitor." This function is described in "The General Rehabilitation Auxiliary."

The training of personnel, whether to improve the capabilities of auxiliaries, to provide full currently accepted qualification for professionals, or to give advanced training to those already qualified, should as far as possible be given in the country or region in which the personnel live and will work. Personnel selected for training should have had contact and experience with the problem of disability in their own country.

Primary Services and their Further Development. The meeting was asked to undertake to identify the services which should be regarded as primary at the inception of a rehabilitation program and to suggest some possibilities of progression, building on the primary services, to intermediate and advanced stages of rehabilitation services. Proposals were prepared by working groups, composed of experts with experience relevant to the respective fields, on the educational, medical, social and vocational aspects of rehabilitation programs. Modified in consideration by the entire meeting, they were approved by it and are presented in "Primary Educational Services in Rehabilitation Programs," "Primary Medical Services in Rehabilitation Programs," "Primary Social Services in Rehabilitation Programs," and "Primary Vocational Services in Rehabilitation Programs."

Consideration was also given to the identification of primary administrative services, and the resulting general observations have been incorporated in "Administration and Coordination", above.

General Recommendations. As personnel training and rehabilitation service programs progress, there should be a continuing procedure to evaluate methods and results and to feed back to all concerned the information obtained through this procedure.

International assistance must be based on the wish and desire in the recipient country to develop rehabilitation services, and the active participation of the related community institutions in the recipient country should be secured. In most instances, the recipient

country should be expected to contribute financially to the project being assisted internationally. The development of services for the benefit of disabled persons in the recipient country is the only acceptable motive for the provision of international aid.

The attention and interest of leading personalities in a country seeking to develop its rehabilitation services should be obtained as early in the developmental process as possible.

An important function of international assistance programs will be to select, prepare and distribute information materials which will be intelligible and useful to all personnel working in the field, overcoming language, cultural and other barriers. Better coordination of the many information services being provided by organizations and universities in the developed countries should be achieved, and more careful attention given to insure the value of each item of information material that is prepared and distributed.

Organizations or governments giving international technical assistance must make certain that no commercial interests are incorporated in the assistance given without full knowledge and agreement of all concerned.

The international utilization of experts to assist the planning and development of rehabilitation services should be undertaken only when there is a clear wish for such aid in the recipient country. Experts must be carefully selected.

Frequently, the most important functions of the expert are to make the people of the recipient country aware of their own problems and to help them find their own solutions. Under no circumstances should it be assumed that the methods and procedures used in the home country of the expert are necessarily the best solution to the problems of the recipient country.

Auxiliaries in Physical Therapy and Occupational Therapy

Agreement was reached on the following guidelines for the training of auxiliary physical therapists and occupational therapists to work in hospitals, clinics and other institutions under the supervision of a qualified physical therapist or occupational therapist.

The decision as to whether a country starts by training auxiliary physical therapists and occupational therapists or fully qualified staff will depend on the educational, social, medical and economic development of that country. Some developing countries are able to train

Another portal of entry to full training would be by formal schooling of shorter duration followed by a pre-physical therapy course (of perhaps one year) in such subjects as physics, chemistry and biology and other appropriate subjects.

For auxiliaries in category c who had worked in a physical therapy department for not less than five years, the school of physical therapy might run an accelerated course of, perhaps, one year to prepare them for entry to the final qualifying examination. Experience would show whether such persons could in one year gain sufficient knowledge of chemistry and physics to enable them to complete the total physical therapy curriculum in its concentrated form and pass the qualifying examination, or whether it would also be necessary for them to participate in a pre-physical therapy course in the subjects noted above. Similar arrangements might be made for an accelerated occupational therapy course.

Aides. There may be scope in some physical therapy and occupational therapy departments for aides who perform routine, non-treatment duties. Such persons should not be confused with auxiliaries.

The Training and Employment of Technicians in Prosthetics & Orthotics

The working group on this subject recommended that, in order to provide an efficient and economic service, the best possible training should be provided and that training at two levels was necessary.

a. The Prosthetist/Orthotist: Responsibilities at this level are primarily of a clinical and supervisory nature. Training should cover both scientific and technical subjects up to university level and should be undertaken over a period of three to four years.

b. The Prosthetic/Orthotic Technician: Responsibilities at this level are for the manufacture of appliances according to specifications given by the Prosthetist/Orthotist. Training should be of a technical nature and should extend over a period of not less than 18 months and should include introductory lectures in scientific subjects. At this level, two grades of work are envisaged: the technician who can work in a variety of materials and the technician trained to work in one material only. Recruitment and training should be such that, if the technician has the ability and received further training, he may progress to the level of Prosthetist/Orthotist.

The periods of training mentioned above are considered to be the minimum necessary to cover the subject matter in sufficient detail. However, it was felt that as an interim procedure somewhat shorter periods of training for technicians could be considered, provided that

fully qualified physical therapists or occupational therapists from the outset. The guidelines, indicated below, suggest a means of meeting an urgent need for patient care; they do not suggest the way in which the professions of physical therapy or occupational therapy should evolve.

Although the following suggestions refer specifically to physical therapy, the training of qualified occupational therapists and auxiliaries will commence on similar lines at the earliest suitable stage in the development of rehabilitation services.

Categories of Auxiliaries. Three categories of physical therapy auxiliaries, working always under the supervision of a qualified physical therapist, are envisaged:

a) Persons with little or no formal education who would be given "on the job" instruction in the physical therapy department to carry out simple physical therapy procedures, e.g. routine mobilizing exercises or to give assistance in teaching walking.

b) Auxiliaries trained to work in limited fields such as leprosy or poliomyelitis. They would be given some instruction in theory; their practical experience would be gained "on the job" while they were assisting with the work in the department.

c) Auxiliaries for general use in the department. They would have achieved a higher educational standard than those in categories a and b because they would require instruction in almost the entire scope of a qualified physical therapist's work -- but at a lower level. They would need lectures in anatomy, physiology and the theory of physical therapy techniques. Use should be made of existing training classes such as those for nurses and laboratory technicians. When occupational therapy auxiliaries are being trained, they and the physical therapy auxiliaries might share some facilities. The practical training would be given by a qualified physical therapist in the department. The auxiliary would spend somewhat less time in assisting in the treatment of patients because of the time spent on more formal training.

Professional Training. The normal entry to full training should be by completion of secondary education with subjects such as physics, chemistry and biology if specified by the training body.

the student had some prior knowledge associated with the subject.

It is recognized that in some instances where services have not been fully established it may be necessary for the technician to undertake some clinical work. In this case, such activity should only be under the supervision of a qualified Prosthetist/Orthotist or a Medical Officer.

The meeting also took cognizance of the approach to the training of prosthetic and orthotic technicians which has been developed and sponsored by the World Rehabilitation Fund. Training is provided through four- to five-month courses in which emphasis is placed on the development of practical skill and knowledge in the manufacture of appliances. Local materials are utilized to the greatest degree possible and, when necessary items are not locally available, low cost imported material is recommended. The usual pattern is to concentrate initially on training in orthotics and to provide subsequent training in prosthetics.

Trainees are selected on the basis of their experience and aptitude. A skilled instructor plans and guides the training program to overcome obstacles of language and custom, and provides frequent follow-up consultation in further instruction.

At the time of the meeting, ten such courses had been completed in cooperation with international and national governmental and voluntary agencies. Some 222 trainees from 19 nations had participated (not individually, as some took part in two courses). It was estimated that as a result approximately 50 new workshops had been started in communities where such services were previously not locally available and were producing about 1,200 appliances per month.

The working group also prepared certain recommendations concerning the general development of prosthetic and orthotic services. These will be found in "Primary Medical Services in Rehabilitation Programs."

The General Rehabilitation Auxiliary

Agreement was reached on the potential utility of a multi-disciplinary worker who could assist in the coordination of functions and provide liaison among those concerned in the rehabilitation process.* It was stressed that this type of worker does not take the place of anyone already in the field and is perhaps primarily of value in the developing countries which have scant and rudimentary services.

The proposed worker would operate at village or similar level and would be responsible for:

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* See also "Primary Social Services in Rehabilitation Programs."

a. Case-finding: He would maintain close liaison with village chiefs, headmen and other community leaders, and would be responsible to identify cases requiring rehabilitation services and to educate parents and clients concerning the need for rehabilitation and its value.

b. Follow-up: Following a client's treatment and release from a hospital, clinic or rehabilitation facility, the worker would insure that instructions were being followed -- e.g. that braces were being worn, that exercises were being carried out correctly and that other prescribed advice was being followed.

c. Vocational Rehabilitation and Training: The worker would advise clients on problems of vocational rehabilitation. He would maintain close contact with the vocational rehabilitation center, if any, and with other sources of guidance and employment.

d. Liaison: This function would probably be the one in which the worker would be most active, and would include:

1) Constant contact with the key people and institutions of the client's community and education of the community as to the needs of the disabled.

2) Stimulating the community to assist and encourage the disabled, and not to treat them as dependent members of the community.

3) In the case of disabled children, liaison with school personnel on the educational needs of the children, encouragement of parents to insure the education of their handicapped children, and investigation of the ways and means of providing educational facilities for disabled children.

4) Action to acquaint the community with the necessity for rehabilitation services and to involve all elements in the rehabilitation program.

Persons chosen to serve as such general rehabilitation auxiliaries should be able to establish close contact with all categories of people, to instill confidence and to carry out a "grass roots" approach to the problems of rehabilitation in the community. Educational criteria and training requirements would vary with the circumstances in which the work is to be performed, but are probably not as important as such personal characteristics as initiative, ingenuity, knowledge of the community and easy rapport with the people. It is probable that as little as six weeks training might often suffice, and that six months training would be a maximum.

It is suggested that, in order to attract and retain the desired type of person, the position should be regarded as a career with prospects of promotion within the position, and not as a stepping stone to other employment considered to be of greater status.

In many communities there already exists someone who carries out functions similar to those described above but not necessarily oriented to the rehabilitation of the disabled. Such workers should be encouraged to interest themselves in rehabilitation problems and in many cases they could perform the duties described above.

Primary Educational Services in Rehabilitation Programs

Services in the Primary Stage. Education of handicapped young persons and adults: This should take place within the general vocational training programs at rehabilitation centers and other institutions, and should include, if possible, literacy training and instruction in the basic educational skills.

Parent Education: Parents with pre-school aged handicapped children (and in particular the mother or mother-substitute) should receive some basic education in the problems of their children and the ways in which they can best help them. The giving of such instruction might be one of the functions of the General Rehabilitation Auxiliary or whatever indigenous person is available to give such training. Such training should be given both to mothers of children who are likely to go on to receive primary education, and to mothers of more seriously handicapped children with little likelihood of school education.

Education of school age handicapped children:

a. While there is a place in developing countries for the traditional concept of the special school (whether this is a day or residential school) much greater thought must be given to and emphasis placed on the education of the majority of handicapped children within the ordinary schools, certainly at the basic level. Residential schools will be needed, however, for children with infectious forms of leprosy and for long-term orthopedic patients. The existence of a small number of such schools may be valuable for in-service training of teachers and as models for future education programs for the more seriously handicapped at the intermediate and advanced stages of provision of services.

b. Handicapped children in ordinary schools should complete the full primary course, which will generally involve from 5 to 8 years of schooling.

c. The ways in which handicapped children are assessed for

suitability for school should be that the child will be able to cope within the ordinary school either in the ordinary classes in the case of the physically handicapped, or spending part of his time in a special class or unit, and part in the ordinary class, in the case of the blind or deaf. The actual scheme adopted will vary widely from country to country. The adoption of this criterion will mean, at this primary stage, the exclusion of certain children or groups of children; for example, the blind child of below average intelligence, the severely handicapped child and others.

d. It should be stressed that the establishment of some link between the education provided at school for handicapped children and some form of vocational training program is absolutely essential.

Provision of teachers and other personnel:

a. All teachers should during their training course be given some instructions by whatever persons are available in the educational and social problems of children with the most commonly seen handicaps in that particular country, since such children are increasingly likely to be found in the ordinary schools. All teachers should also be encouraged to help in case-finding in their home area.

b. Teachers responsible for special classes (e.g. for the blind or deaf) should be fully qualified primary school teachers with prior experience in teaching non-handicapped children. It should be recognized that considerable diversity may exist in the length of the specialized training which is necessary for them, but such training should be given within their own country. The possibility of their receiving some incentive should be considered, possibly related to the length of their additional training.

c. Each country's Ministry or Department of Education should have at least one administrator with overall responsibility for the education of handicapped children, preferably with prior experience in this field.

Services in the Intermediate Stage. As progress beyond the primary stage of development becomes possible, special attention should be given to:

a. The initiation of research programs into ways in which the basic services described above could be modified and improved.

b. The establishment of a rudimentary assessment service for handicapped children.

Services in the Advanced Stage. As further progress makes additional developments possible, consideration should be given to:

a. The provision of secondary education for handicapped children.

b. The provision of appropriate educational facilities for the categories of children that were excluded during the primary stage.

c. The improvement of existing assessment facilities and their staffing with fully qualified indigenous personnel.

Primary Medical Services in Rehabilitation Programs

The working group on medical services stressed the importance of prevention of disability which can effectively minimize the amount of rehabilitation service needed.

Services in the Primary Stage. Primary medical services should make maximum use of existing local facilities.

Rehabilitation of the physically disabled should be the first consideration.

Primary medical services in rehabilitation programs should consist of:

a. Medical guidance and advice.

b. Physical therapy, aimed at making the patient ambulatory and/or able to take advantage of whatever other services might be available, particularly educational, social and vocational. This may be achieved by the use of exercise therapy and with equipment that can be obtained and maintained locally.

c. Prosthetic and orthotic services at the level of supportive appliances for the lower extremities.

Services in the Intermediate and Later Stages. There can be no rigid plan for progression from the primary to later stages. It is recommended that progress be sought along the following lines, taking into account local needs and resources, the results achieved in the initial stage and the economic, social, medical and educational development of the country concerned.

a. Training of specialized medical and of paramedical personnel.

b. Improvement and expansion of primary services.

c. Addition of psychological and psychiatric facilities.

d. Addition of occupational therapy.

e. Addition of speech therapy.

f. Prosthetic and orthotic services should proceed to:

1) Lower limb prostheses
2) Spinal appliances
3) Diversification of design
4) Upper extremity appliances and prostheses

g. Establishment of special units for certain categories of disability, such as blindness, deafness, cerebral palsy, spinal injuries and others as required.

h. Utilization of mobile units to carry services into rural areas and ultimately to develop peripheral clinics and permanent centers.

i. Research

Prosthetic and Orthotic Services. The working group on the training of prosthetic and orthotic technicians also reported the following recommendations concerning the establishment and development of services in that field.

Having in mind the varying levels of development in the various countries, several methods can be considered for the provision of services:

a. In countries where no facilities exist, the services of an accredited consultant should be obtained. Since his duties would be to establish a service and train the necessary staff, the appointment should be for a long term.

b. In countries where rudimentary services exist, a similar procedure should be followed.

c. Where functioning services exist, short term consultants should be employed to provide up-grading courses and to assist in planning expanded services for the future.

d. Regional training centers may provide valuable facilities for countries in several stages of development. The functions of the center are:

1) To provide prosthetic and orthotic services.
2) To train the various levels of staff required (not only prosthetic/orthotic personnel, but also the other disciplines involved in the rehabilitation process).
3) To undertake research and development as it applies to conditions in the region.

4) To serve as a demonstration unit in connection with the eventual establishment of national centers in the countries of the region.

Since prosthetic/orthotic services constitute an integral part of the complete rehabilitation program, they should be established and developed in conjunction with other rehabilitation disciplines, particularly physical therapy.

Primary Social Services in Rehabilitation Programs

Services in the Primary Stage. The following identification of services is based on the following assumptions:

a. A rehabilitation service (to be referred to as the rehabilitation center) exists or is being developed somewhere in the country concerned.

b. Services of trained professionals are not available outside this center, at least not in most parts of the country.

The basic social services that are required need to be available both outside the center at village level and in the center itself.

Outside the center, the basic services include:

a. Case-finding, including identifying and helping disabled persons in such institutions as orphanages, homes for maladjusted children, etc.

b. Establishing rapport with handicapped persons and their families.

c. Effecting liaison between the disabled and the rehabilitation center, the school and other institutions able to assist.

d. Assisting in the solution of financial problems.

e. Providing follow-up services, including assistance in finding employment opportunities such as participation in crop harvesting, shepherding family or village cattle.

f. Elementary record keeping.

These functions may be described as "talking, listening and encouraging," and should be understood to be, as basic services, at a very elementary level. These are services which, at a much higher level,

would be provided by a trained social worker or possibly by a team consisting of a social worker, counsellor, psychologist and placement officer. At this basic level, they could be provided by a "general rehabilitation auxiliary" or "village visitor" (see "The General Rehabilitation Auxiliary"). This worker should participate in a short training program (from a few weeks to six months) in the rehabilitation center with the main emphasis on observing the services of the center. The success of this type of worker will depend more on his individual characteristics and personality than on his educational background.

In the center, the basic services include:

a. Effecting liaison between the rehabilitee and his community, family, village visitor and others.

b. Providing recreational services and other help in filling the many free hours when no professional treatment service is taking place.

c. Assistance in the solution of financial problems.

d. The taking of case histories, if this is not assigned to another service.

At a higher level of development these services would be provided by the forementioned professionals and even others. At this primary level, they might well be provided by volunteers who have been given some instructions in the general principles of rehabilitation and an opportunity to observe the activities of the center for a short time before starting their own work.

Services in the Intermediate and Later Stages. The basic services obviously can be gradually developed, in accordance with available resources and existing needs, to a more sophisticated social service program by providing additional training to the persons engaged in these activities. If social welfare assistants or similar trained persons are available, some or all of the described duties may be assigned to them unless they are already charged with more work than they can efficiently accomplish.

Primary Vocational Services in Rehabilitation Programs

Introduction. Before a vocational rehabilitation service is initiated, a careful appraisal of the situation of disabled persons in relation to the economic and social structure of the country concerned should be undertaken. On the basis of the findings it should be decided whether it would be most advantageous to have a local, regional

or national program for all disabled or whether it would be preferable to concentrate on one or two major disability groups. It should also be decided which services are first needed: vocational guidance, vocational training, special placement services, sheltered employment, a rehabilitation center or something else. Since, in developing countries, the majority of people live and work in rural areas, a vocational rehabilitation service for the disabled in these countries should give particular emphasis to providing work opportunities for the disabled in agricultural occupations and rural trades.

Even if the initial program is restricted to only certain disabled, it should aim at ultimately providing services for all disabled persons, whatever the origin and nature of their disability, and whatever their age, provided that they can be prepared for and have reasonable prospects of securing and retaining suitable employment.

The main objectives of any vocational rehabilitation service which should be taken into account at the inception of any program should be:

a. To demonstrate and improve the working qualities of the disabled.

b. To emphasize their abilities and working capacities, not their disabilities.

c. To promote working opportunities for the disabled so that they may become as self-supporting economically as possible.

d. To overcome discrimination against employment of the disabled.

Establishment of the Service. As a first step, it is suggested that a vocational rehabilitation service for the disabled should be provided only to those straightforward cases which have a reasonable expectation, on completion of rehabilitation, of obtaining and holding a suitable job in the open labor market in either urban or rural areas.

The basic services should include:

a. An identification and referral procedure located at an existing community service (e.g. hospital, social welfare office, voluntary agency or other).

b. Assessment and guidance program, it being appreciated that, in the absence of qualified personnel such as psychologists, occupational therapists and trained evaluators, vocational assessment and guidance would need to be based on simple, practical work assessment techniques.

c. Vocational training courses. In this connection, it is emphasized that the fullest possible advantage should be taken of any existing training facilities for the normal population, such as vocational training centers and schemes in urban and rural areas, technical and commercial schools, colleges and universities. On-the-job training and apprenticeships should be encouraged. If this approach fails or is not feasible, consideration should be given to the establishment of separate vocational training facilities in line with current opportunities in the labor market. Special emphasis should be given to relating the vocational training to agricultural occupations and rural trades.

d. Selective placement services should also be developed, if possible, in coordination with existing placement services, or through such facilities as social welfare or community development services, voluntary workers or others.

e. Sheltered and semi-sheltered employment: In the absence of suitable opportunities for the disabled in the "open" labor market, sheltered and semi-sheltered schemes may be the only means of creating employment possibilities for the disabled, of demonstrating their working capabilities and of proving the economic and social value of vocational rehabilitation. Such schemes may include workshops, cooperative farms, self-employment in homework projects and others.

f. Follow-up: A plan of review and evaluation is essential, especially in a pilot project, to evaluate the degree of its success and effectiveness.

Best Means of Providing the Basic Services. It is recommended that the above listed basic elements could be best introduced in the form of a simple pilot vocational rehabilitation center and workshop, located preferably in close proximity to a hospital or clinic and housed in existing premises. Such a multi-purpose center and workshop, offering basic assessment, vocational training, selective placement and sheltered employment facilities, could well be the starting point for a national rehabilitation program.

The pilot project could serve as a research, demonstration and staff training center. It should be closely associated with existing medical, social and educational services. Efforts should be made to provide basic education for illiterate disabled receiving services at the center.

Personnel Requirements. The minimum personnel needed for the basic services would be as follows:

a. Identification and referral could be performed by existing

social welfare officers, community development workers, volunteers and others.

b. Vocational assessment and guidance ideally should be undertaken by a psychologist, an occupational therapist and vocational instructors and evaluators. In most developing countries, the main burden will fall initially on the vocational instructors.

c. Vocational training staff should be appropriately qualified trade instructors.

d. Selective placement and follow-up should be carried out by a selective placement officer with a good knowledge of commerce and industry, a real feeling for the work and a good personality to deal with employers.

e. Sheltered employment facilities must be operated with a business minded manager and appropriate technical staff.

It should be emphasized that, in the early stages of development, the above services could be provided by a small number of staff. For example, the identification, referral, selective placement and follow-up could be undertaken by the same person; assessment, guidance and training could all be performed by the instructional staff.

Staff Preparation and Training. All staff employed in the basic service should be required to attend orientation courses embracing medical, social, psychological, educational and vocational aspects of rehabilitation. Such courses, given over a period of four to six months, could be provided on an "in service" basis by personnel qualified in the various specialities mentioned. Refresher courses should be given at regular intervals to keep the staff up to date regarding new methods and techniques. Advanced training for the best qualified personnel should be sought through bi-lateral and international technical assistance programs.

Extension of Services. Once the pilot service has been firmly established, it should be gradually extended to other urban and rural areas. The eventual aim should be to provide a comprehensive service for all disabled, including the multiple-handicapped, staffed by fully qualified personnel. Such a service would be of economic as well as social value to the country.

Extension of the service, in both the intermediate and advanced stages, will require the fullest possible support from the government, from voluntary organizations and from the community in general. The service should be developed as an integral part of an overall national national rehabilitation program in line with the country's social and rehabilitation program in line with the country's social and economic development plans for rural and urban areas.

CHAPTER VI - ELEVENTH WORLD CONGRESS EVALUATION

Introduction

In the forty years since the International Society first initiated its world congresses, a unique and useful purpose has been served. Personnel from all of the disciplines engaged in the rehabilitation process have come together at these meetings from all parts of the world to exchange information. The congresses have attracted participants with a wide range of professional backgrounds whose involvement in local and international rehabilitation activities have varied greatly. They have been designed primarily to serve the following purposes:

to expose recent advances in rehabilitation technology and disseminate information of value to rehabilitation workers throughout the world,

to foster a broad exchange of views about international needs among the professional, auxiliary, and voluntary personnel concerned with rehabilitation,

to focus attention on the needs of the physically and mentally disabled within the host country and throughout the world in order to stimulate increased governmental and public support for programs that serve the handicapped,

to enable member organizations to identify with the International Society as their representatives participate in meetings of its governing bodies.

As the congresses have grown in size and importance, it has become essential to develop procedures for evaluating their success. Evaluations of congresses conducted during the last ten years have at times been highly structured. At other times less formal evaluations have been conducted. At all times, these evaluations have attempted to determine if the congresses effectively serve their purposes and how they might have been improved. In the following evaluation, a summary is presented of the Eleventh World Congress and participant observations about it. A brief description of past evaluation procedures and findings is included. Recommendations were developed by the Secretariat of the International Society on the basis of both present and past evaluations.

Background Information

The Eighth World Congress of the International Society was held in New York City, U.S.A. in 1960. Almost four-fifths of the more than

3,000 participants in this Congress were from the host country and its neighbor, Canada. An analysis of the professional affiliation of the participants attending this Congress indicated that approximately 40% were physicians or administrators and the majority of the remaining participants were either physical therapists, occupational therapists, psychologists, social workers, teachers, or volunteers, A similar distribution of professional affiliation was noted among the 1,700 delegates to the Ninth World Congress held in Copenhagen, Denmark in 1963.

Evaluation questionnaires were distributed to participants during both of these Congresses. In both instances, it was found that only a small percentage of delegates returned questionnaires. During the Eighth World Congress, five percent of the participants returned questionnaires initially and almost one year of intensive follow-up activity was required to obtain responses from a total of ten percent of the participants. Statistics regarding reactions to the Ninth World Congress were based upon responses from less than ten percent of the delegates. An elaborate procedure for coding the responses on computer punch cards was devised during the Eighth World Congress evaluation to allow statistical procedures including factor analysis to be used in analysing the nature of participant reactions. Yet the participant opinions which were reflected in both evaluations appeared to be quite similar.

The participants in both the Eighth and Ninth World Congresses generally felt that the main value of a world congress lay in its ability to provide opportunities for delegates to form new associations and contact old friends. They considered the exposure to new ideas and approaches which these contacts gave them to be more important than learning specific skills or techniques. During both Congresses, comments about the nature of the technical program were also quite similar. In general the participants suggested that:

> fewer sectional meetings be conducted simultaneously and the least related sessions be held at the same time; large plenary sessions be broad in scope and of exceptional quality; papers be distributed in advance of the sessions whenever possible; programs be presented at higher scientific levels; opportunities for discussion be fostered in sectional meetings and through informal social activities; the subject matter and the professional background of participants be less heterogenous; tours be held throughout the week; and the broad nature of the Congress program be retained.

A formal evaluation was not conducted during the Tenth World Congress which was held in Wiesbaden, Federal Republic of Germany, in 1966. A detailed analysis of the reactions of the approximately 2,000 participants in that Congress is not available.

Organization and Physical Arrangements

The Eleventh World Congress was organized by the International Society's Affiliated National Organization in Ireland, the National Rehabilitation Board, and was held at the Royal Dublin Society (RDS) premises in Dublin from September 14-19, 1969. The RDS premises are used throughout the year for exhibitions and horse shows. During the Eleventh World Congress special areas were designated within this facility for the Congress meetings, film theater, international exhibition center, registration center and information center.

Separate registration and information areas were utilized to provide Congress participants with materials, delegate attendance lists, housing information, and messages. A large centrally located lounge area was available and a message board and paging system were located nearby at the information desk. Daily film shows were presented throughout the Congress week in the International Film Theater. The International Exhibition which housed a wide variety of exhibits within one centrally accessible hall was also open throughout the week. Visitors to the exhibition other than Congress delegates were charged a small admission fee. All of the Congress program meetings, with the exception of special sessions organized by three of the International Society's committees, were held in the RDS building to facilitate attendance. Cafeteria and dining areas were established on the grounds. Special arrangements were also made to enable easy access for disabled participants.

Staff members from local news media were given texts of speeches and news releases on a day-to-day basis to help publicize Congress events. Representatives of the three major international news services and the United States Information Agency were supplied with material about the Congress.

Registration

More than 2000 delegates from 65 countries participated in the Eleventh World Congress. Approximately one-third of these participants were from the host country and the United Kingdom and one-quarter were from North America. The remaining participants came from the wide variety of other nations represented at the Congress. While the total

attendance was similar to attendance at previous congresses held in the European region, it appears that a greater proportion of the delegates than in the past were from different countries. Participants who registered early for the Congress were charged reduced fees. Part of the cost of producing the Congress Proceedings was included within the registration fee. All full Congress registrants are, therefore, entitled to receive one copy of the Proceedings without additional charge as soon as it is completed.

Program

The content of the Congress program was organized by a planning committee of the host organization with extensive cooperation from the Secretariat of the International Society. One general plenary session was held each morning and was usually followed by three sets of five simultaneous sectional sessions. Sixty-five meetings were held in all as part of the Congress program. More than 30 minutes within each 90 minute sectional meeting were allotted for audience discussion. Simultaneous translation was organized using sound proof booths for the translators and head phones for the participants and was provided during all sessions in the three Congress languages--English, French, and German. Translators could be heard through their booths, however, in the smallest sectional meeting room. The speakers invited to present papers at these sessions represented a greater number of countries than had been represented in past Congress programs.

A new feature in the program was the use of working groups and sectional sessions to formulate "Guidelines for the Future" in the educational, social, vocational, and medical aspects of rehabilitation. Draft recommendations in each field were prepared prior to the Congress by expert working groups. These drafts were made available to the participants for their comments and were also discussed during special sectional meetings. Some interest and participation was generated from among the delegates and their suggestions were incorporated within revised drafts of the recommendations.

Although no official count was made of the attendance at each session, it was estimated that only several hundred of the Congress delegates attended Congress sessions at any given time.

Additional technical sessions were organized by the ISRD's World Commission for Cerebral Palsy; International Committee for Technical Aids, Housing and Transportation; and Committee on Speech and Hearing. Specialized pre-Congress seminars were also organized by other committees of the ISRD as follows:

> Fourth International Seminar on Special Education, Cork, Ireland, September 9-12, 1969, sponsored by the Committee on Special Education.

Fourth International Seminar on Vocational Rehabilitation, Galway, Ireland, September 7-12, 1969, sponsored by the World Commission on Vocational Rehabilitation.

Seminar on Social Epidemiology of Arthritis, Dublin, September 13, 1969, sponsored by the Advisory Committee on Arthritis.

Tours and Hospitality

A variety of activities was arranged for Congress participants to complement the technical program sessions. Formal social activities included a State Reception at Dublin Castle and a Buffet Dinner and Dance. Extremely large numbers of people were accommodated at these two gala events. A special Festival Club area in downtown Dublin was made available to Congress participants during the evenings for conversation and refreshments. Tours were organized throughout the week for small groups of visitors to each of 23 nearby rehabilitation facilities. Only fair attendance was reported during these tours. Special tours to surrounding points of interest and other activities were also organized for the approximately 350 associate Congress registrants. These events were well attended.

The Congress organizers made arrangements for participant housing at a number of locations throughout the city. Overbooking was initially a problem in one or two hotels but alternate accommodations were soon made. Each registrant received a city bus pass with the compliments of the National Transportation Company to enable him to use local transportation without charge. Special bus transportation was provided to the formal social functions by the congress organizers free of charge, as well.

Awards

A feature of this Congress, as in past congresses, was the presentation of awards. The Irving Geist International Film Awards were presented for the best film for professional audiences and the best film promoting rehabilitation to the general public. The Bell Greve Memorial Award and the Sir Geoffrey Peto Memorial Award were given for the best exhibits. The Albert and Mary Lasker Awards were presented to three individuals and one organization for distinguished service to the physically handicapped.

Participant Observations

Members of the International Society's Secretariat sampled delegate opinion about the effectiveness of the Eleventh World Congress throughout the Congress period. The impressions gathered at random from approximately 3% of the delegates were then analyzed.

Organization and Physical Arrangements. Most of the participants interviewed were quite pleased with the organization of the Eleventh World Congress. They were generally satisfied with the arrangements made for housing, transportation and interpretation. They commented on the quality and exceptionally interesting variety of exhibits. Participants did report difficulty in attending the film theater and the tours because they conflicted with sectional meetings scheduled at the same time. A number of people expressed an interest in seeing the film programs made more prominent. Although the press office was not located in the main Congress area, domestic news coverage of Congress events was reported to be quite good. International coverage was not considered to be as effective since advance texts of Congress papers were not supplied to the international wire services for transmittal during light trafic periods.

Program. Many of the participants interviewed were well satisfied with the content and organization of the Congress program. An almost equal number of those questioned reiterated comments stated at previous congresses. They did not criticize the coordination of subjects, format of the sessions, and choice of topics although in the past these aspects of the program had been criticized. However, these participants did cite other problems. They found it difficult to choose between simultaneous sessions of equal interest. The broad coverage of many rehabilitation-related subjects, they felt, had resulted in much of the information presented being old, too general, and of little interest. Papers varied greatly in quality and some participants felt that this was the result of trying to appeal to delegates from too wide a range of professional background. Additional speakers of greater renown were requested. Despite the fact that every effort was made to ensure discussion time during sectional meetings, some participants commented that the time allotted was inadequate. Smaller meetings with fewer participants were also suggested. Some members of the Guideline working groups reported having insufficient time to coordinate their recommendations with other group members. They suggested that more carefully selected working group members be invited at an earlier date to draft recommendations further in advance of the Congress.

A contrast of opinion regarding the content of the program seemed to be present between those participants who were particularly interested in acquiring technical information and those participants representing organizations, committees, and ISRD affiliates who were more interested in arranging organizational and personal contacts.

The latter group was generally satisfied with the content of the program. The former "technically-oriented" group frequently requested fewer sessions of a more specific nature, improved scientific quality, and increased discussion time.

Informal and Formal Social Activities. Many participants were pleased with the use of a large centrally located hospitality area rather than small scattered lounge areas. They found this area to be particularly useful in establishing informal contacts. Some participants reported difficulty in conveying messages to other participants as the message board was not prominent. The sound of the paging system carried into the sectional meeting rooms and it could not, therefore, be used when meetings were in session. As a result, messages were announced extremely rapidly during the periods between meetings and often were not properly heard.

Since housing and dining facilities were located throughout the city and the organized social functions were extremely large, participants also often found it difficult to contact each other after the daily program. Restaurant facilities were provided within the Congress center, however, the snack lunch facilities were inadequate to accommodate all participants and the set meals available were not preferred. Since the RDS was located some distance from the center of Dublin, many participants found difficulty in lunching in the time allotted.

It appears that delegates with formal organizational and/or ISRD affiliations experienced less difficulty in being reached by other delegates and establishing their own contacts than did delegates without formal affiliations. Some participants specifically requested that a listing of organizational representatives be provided to help them in establishing contacts.

Many participants commented on the effective organization of the formal social events. They were also impressed by the exceptional hospitality of their Irish hosts during these functions and throughout the Congress period.

Secretariat Recommendations

It is important to measure the success of the Eleventh World Congress both in terms of its ability to serve the purposes set by the International Society and to satisfy the varied interests of the participants. In these respects, it appears that the Eleventh World Congress succeeded remarkably well. Informational material of interest

to a large and diverse international group was presented while opportunities were also provided for both formal and informal contacts.

Nonetheless the participants sampled during this evaluation did indicate their interest in an increased exchange of technical information during the Congress. They also expressed a need for additional opportunities to arrange contacts with other delegates. Recognizing the opinions expressed by participants and considering the functions of the World Congress in the overall program of the International Society, the Secretariat has proposed the following recommendations for the Twelfth World Congress.

In order that the Twelfth World Congress may be organized efficiently and effectively:

a) continued use should be made of one central building which includes facilities for all meetings, films, and exhibits. The use of simultaneous translation during all sectional and plenary sessions should be continued.

b) well designated information and registration centers should be established. Adequate facilities should also be available for lunches and snacks.

c) additional measures should be taken to increase the international and national exposure of Congress events as a means of stimulating public concern for the disabled. A centrally located press office should be established with facilities for conveying advance texts of speeches and news releases to the news staffers in attendance.

As stated under the new Constitution regulations, the Secretary General will plan the technical program of the Twelfth World Congress in consultation with the Congress Committee of the host organization, the member organizations, and the Society's scientific and technical commissions and committees. In order to strengthen the program of the Twelfth World Congress and increase its value to participants:

a) international cooperation in planning the program, particularly among members of the International Society's four standing Commissions, should be emphasized. In this connection, it may be advisable for the Council to establish a Program Advisory Sub-Committee which would meet during the preliminary program planning period.

b) if it is thought advisable to secure the services of a greater selection of major speakers who would otherwise be unavailable, consideration should be given to providing funds for speaker honoraria, travel expenses, reduced registration fees, or other facilities as may be necessary.

c) major program topics should be planned and speakers decided upon, at least two years in advance of the Congress date and invitations should be extended to speakers at least one year in advance.

d) recognition should be given in planning to the need for an exchange of information both generally across discipline and professional levels and specifically within technical groups. The format of the Congress program could be modified to better reflect the need for both kinds of information. In addition to increasing efforts to invite speakers from varied professional levels and experience backgrounds, it may be considered of value to use more innovative techniques during the Congress sessions (round-table discussions, audio-visual presentations, debates, panels) to stimulate greater speaker-audience interaction.

e) complete programming information should be distributed prior to the Congress and, if at all possible, brief abstracts of the papers and introductory biographical data about the speakers should be included.

f) if delegate participation in and support of substantive actions such as the Guideline recommendations are desired during the Congress, well planned procedures should be instituted for developing useful working documents prior to the Congress and for distributing the necessary information to all of the participants.

g) special attention should be given within the Congress program to publicizing the 50th anniversary of the International Society's establishment.

h) further consideration should be given to the manner in which the Congress Proceedings are published. In the past, all papers have been printed in a single Proceedings volume without respect to their individual merit or lasting interest. The utility of different forms should be discussed. Other methods could be to publish "select papers," requiring an evaluation committee to choose the papers most indictive of important technological advances, or to collect papers of interest to specific groups and publish them separately.

In order to further delegate opportunities to contact and communicate with one another at the Twelfth World Congress:

a) centrally located lounge areas should be available for delegates and as many opportunities as possible should be provided for delegates to meet each other in small groups both formally and informally during meals, in lounge areas, and through social activities.

b) a more effective message relay center should be established. A well publicized center might combine paging, message, and delegate information functions and could, if feasible, have pigeon hole message boxes for each delegate. Frequently sought participants such as the congress organizers or international organization representatives might use special signal devices in conjunction with the paging system.

c) a technical assistance center should be available where delegates could talk with representatives of international organizations offering assistance for rehabilitation programs or contact other participants who might be recruited to assist in their programs.

For a more comprehensive evaluation of the role that world congresses serve in fulfilling the purposes of the International Society, the following kinds of information would have to be known:

a) the extent to which the various professional, auxiliary, administrative, and voluntary groups concerned with rehabilitation are being reached by the activities of the International Society.

b) which activities (technical assistance projects, publications, consultant visits, information services, meetings, conferences, and congresses) most effectively serve the needs of the above groups.

c) if meetings, conferences, and congresses appear to be a highly effective method of serving the needs of people active in the rehabilitation field, which types of meetings (regional conferences, specialized seminars, international congresses) are most useful.

If a more complete assessment of the function of the World Congress is desired, further consideration should be given prior to the Twelfth World Congress so that future decisions may be made by the governing bodies of the International Society at that time.

CHAPTER VII

AN EXPLORATORY STUDY OF MULTI-LINGUAL REHABILITATION TERMINOLOGY REFERENCES

Introduction

The International Society for Rehabilitation of the Disabled has long conducted a program for translating pamphlets and articles pertaining to rehabilitation and its quarterly periodical, the International Rehabilitation Review, is published in English, French, Spanish, and Japanese. At the present time, because of the widespread interest in international communication, the International Society receives frequent requests to assist in the production of new bi-lingual or multi-lingual material, especially rehabilitation terminology references.

In order to facilitate its thinking concerning possible participation in one or more of these projects, and to further the coordination of the excellent efforts and accomplishments of the various groups engaged in similar work, the Society included a sectional meeting on the subject at the Eleventh World Congress in Dublin. The meeting, entitled "Development of an International Rehabilitation Terminology", was held on September 15, 1969.

Invitations to participate in the meeting were extended to several national and international groups who were known to be engaged in multi-lingual terminology projects. Each one was asked to send a representative prepared to give a brief description of the purpose, procedure and status of his project.

It was hoped that these presentations would lead to a discussion of the over-all problems of inter-lingual communication in rehabilitation, and that out of this would develop an indication of the appropriate role of the ISRD as participant, sponsor, or co-ordinator, to promote better understanding.

The subject was of such general interest that a large number of Congress participants attended and took part in the discussion that followed the prepared presentations. In fact, because of the timeliness of the subject, and the need to explore it further, a supplementary meeting was held two days later to continue the exchange of information. Dr. Willian M. Usdane, at that time Chief, Division of Research and Demonstration Grants, Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare, was Chairman of the meeting.

What was originally planned as a small round-table discussion, turned out to be a large meeting, attended by many people interested in

numerous aspects of rehabilitation terminology and improved communication. A good deal of scattered information was offered regarding terminology projects planned or undertaken by other organizations, but it was clear that an on-going central pool of such information, current and complete, was urgently needed. It was proposed that a clearing-house of this type could not only prevent duplication of efforts, but could also serve to answer many of the difficult philosophical and technical questions that the production of a multi-lingual document poses. As a result of this meeting, it was suggested that the ISRD compile a list of the pertinent available references, and identify the committees concerned with rehabilitation terminology. The information thus obtained, could be expected to lead to future cooperative efforts and improved publications.

Data Collection

A simple questionnaire was designed, requesting information regarding the following items pertaining to rehabilitation or related subjects:

1. Multi-lingual rehabilitation vocabularies, glossaries or dictionaries that have been produced and/or published.

2. Other useful terminology references (mono-lingual, bi-lingual or multi-lingual) on subjects related to rehabilitation.

3. The need for additional multi-lingual rehabilitation references.

4. Professional or lay groups most likely to need multi-lingual rehabilitation references.

5. Organizations or groups currently developing multi-lingual reference material pertaining to rehabilitation.

To this was added a cover letter briefly describing the study and asking for cooperation. It was assumed that the recipients of the questionnaire would understand that the term rehabilitation was applied to both children and adults, and interpreted broadly, therefore, the term "habilitation" was not used anywhere in the study.

The questionnaire and cover letter were mailed to the member organizations of the Council of World Organizations Interested in the Handicapped (CWOIH) as well as to its cooperating inter-governmental organizations. Where there was no international organization taking responsibility for an applicable disease entity or profession, or where such an organization could not be reached within the structure of

the study, one of the corresponding national organizations was contacted.

Special letters accompanied the questionnaire to those individuals who had spoken at the Dublin meeting, to representatives of the groups known to be engaged in rehabilitation terminology projects, and to a few persons in related areas of interest.

Information was also collected by means of conferences with individuals in New York City, including rehabilitation specialists, linguists, and professional interpreters. These people gave magnanimously of their time, wisdom and library material to further the goals of the study.

Professional organizations, health agencies, and individuals in 18 countries were contacted. These included a wide variety of areas of interest ranging from physical medicine to international translation and standardization. Replies were received from individuals in 38 international organizations and 23 individuals in 19 national agencies. Almost all of the replies furnished information that was useful to the study. Only a small percentage of those returning questionnaires indicated that they had nothing to offer or that it was inappropriate for them as individuals to speak for their organizations.

Findings

Interest. The most salient finding of the study was the intensity of interest in the problems of inter-lingual communication among the professions concerned with rehabilitation. The majority of those who responded to the questionnaire supplied multi-lingual material and references as well as pertinent comments. Only three people of all those replying to the question "Do you consider the references you are now using satisfactory?" indicated satisfaction with available materials. These individuals, however, either felt no need for multi-lingual references or were developing references of their own.

Types of Reference Materials. Early in the project it became obvious that the profession used several different types of reference material, pertaining to quite divergent aspects of rehabilitation. The material submitted varied accordingly in content, format, selection of languages, and purpose. The documents dealt with subjects varying from those directly related to rehabilitation such as physical therapy, prosthetics and orthotics, and psychiatry to more peripheral fields such as legislation and dentistry. Publications related to terminology development, catalogues, directories and bibliographies

were also received. Material varied in shape from simple pocket size cards and leaflets with phrases and words for clinical use to more elaborate hard-cover texts and loose-leaf binder materials. A particular need was expressed for additional references in the following fields: pre-vocational evaluation and training, occupational therapy, special education, anatomy, physical therapy modalities, epilepsy, and social work.

Appraisal of Available References. A few existing multi-lingual rehabilitation terminology references were reported to have been used extensively and to have continued to prove valuable over the years while others have been subject to various degrees of criticism. Individual publications were assessed as being: "of inferior quality... confusing because only one term is given where there are actually several recognized terms for the same concept or item...inadequate in cases where the same term has a different meaning in another language... incomplete...not up-to-date...not simple enough...not technical enough." In addition, there is still much controversy regarding terminology definition and classification in many areas of rehabilitation and in certain fields, where basic concepts are still in the developmental stage, it was emphasized that it was undesirable to attempt to crystallize terminology.

Languages. Many of the vocabularies and glossaries submitted were drawn up in the three or four working languages of the international organizations which prepared them and these were for the most part European languages. A lesser number of Asian and some African language translations were also included among the references. A desire was voiced for additional references in English, French, German, Spanish, the Scandinavian languages, Italian, and Portuguese, in approximately that order. Some people felt that there was a marked shortage of rehabilitation material in Spanish.

Readership. Replies regarding the audience for whom a specific publication was issued, or for whom a multi-lingual publication was needed (i.e. professional to professional; personnel to patient; educational media, etc.), generally reflected the programs or disciplines of the organizations or individuals responding. Since most of the replies were received from agency personnel, the largest number listed "professional to professional," as of greatest importance with "educational media" a close second. The groups concerned with direct care to patients felt a need for help in translating technical terms into lay language, and for a "phrase-book" type of publication to assist in treating patients. A need was expressed for terminologies to serve a variety of purposes including: communication between international organizations, training of lay workers and volunteers, translation of documents and conference papers, and inter-staff communication in facilities with personnel from differing cultural and language backgrounds.

Current Terminology Projects. The final item on the questionnaire requested information about organizations planning or conducting projects to develop multi-lingual terminology references containing terms of use to rehabilitation workers. A few organizations, national committees and individuals who are presently working in this field were identified in addition to the groups cited during the terminology meeting at the Eleventh World Congress. Different types of projects in progress that came to the attention of the study include:

A UNESCO study of the terminology used in the field of special education for handicapped children and young people being conducted by the Division of Equality of Assess to Education,

A Special Committee on International Nomenclature of Diseases of the Council for International Organizations of Medical Sciences which hopes to develop an international system of standardized nomenclature for the whole of medicine and has initiated a pilot project using English and French,

A Terminology Committee of the International Association of Logopedics and Phoniatrics which is attempting to develop a scientifically accurate and internationally recognized terminology in this field,

A Scandinavian-English Rehabilitation Terminology project which is producing an English/Scandinavian rehabilitation dictionary of special terms and concepts used within the broad field of rehabilitation encompassing the medical, paramedical, vocational, and social rehabilitation of the physically and psychiatrically disabled and also aged. The dictionary will include English, Danish, Finnish, Norwegian, and Swedish,

A Technical Committee of the International Organization for Standardization dealing with dentistry which will attempt to define clinical and technological dental terms in English and French.

Conclusions and Recommendations

Judging by the examples submitted to the study, there were almost as many ways to attack the problem of inter-lingual communication as there were groups willing to undertake the task. A review of the material indicated that most of the references were prepared by one or more professional people who were familiar with the subject to be translated, and who spoke two or more of the selected languages.

As more national languages are used as the primary language of instruction particularly in the developing countries of the world, the need grows for terminology references to translate and explain the same concept in many languages. Yet it has been found in this study that most of the agencies responding believe that multi-lingual terminology references with definitions in English and perhaps one other European language are the most useful.

Similarly, while terminologies will be increasingly needed for the training of auxiliary level and lay personnel to work with disabled patients, the respondents generally thought in terms of references for use among professionals rather than for communication with patients. Comments regarding available completed references and projects in progress indicated that a wide variety of problems must be overcome to develop effective rehabilitation terminology references of any type.

The ISRD recognizes the importance of accurate communciation in all phases of the rehabilitation process, i.e., among members of the rehabilitation team, between the practitioner and the patient, among organizations sponsoring rehabilitation programs, and among rehabilitation personnel in all parts of the world. On the basis of this preliminary study of multi-lingual rehabilitation terminology references, the ISRD proposes the following suggestions for further efforts in this field.

Developing Additional Glossaries. An immediate need exists for additional simple pocket size terminology guides in different rehabilitation-related specialties for use in clinical situations. Any group wishing to undertake the task of preparing these guides is encouraged to do so taking these preliminary guidelines into consideration as far as possible. It would be particularly useful to develop guides in fields such as special education, occupational therapy, vocational rehabilitation and speech and hearing. A more inclusive physical therapy glossary is also needed and could possibly be developed in conjunction with an occupational therapy terminology.

Refining Professional Terminologies. In view of the fact that more sophisticated references are already needed among professionals, both in their individual roles and organizational functions, it is important that uniform use of terminology be achieved within the various fields of rehabilitation. Until the numbers of terms agreed upon are extended, no mono-lingual or multi-lingual terminology references can be considered completely reliable. For the development of rehabilitation terminologies to be used in specific aspects of rehabilitation, continued study is necessary, a willingness must exist among experts to make concessions here and there in order to reach general agreement about terms, and approval by the applicable professional organizations, nationally and internationally, must be

attained. Those professions and disciplines with fairly well established terminologies are in the best position to initiate glossary compilation.

Planning Terminology References. After selecting those words in a given field judged to be of the greatest importance, any group organized to develop a multi-lingual rehabilitation terminology reference would do well to obtain consultation from, or include on their committee, individuals with varied professional skills and experience. When determining the most useful method for presenting glossary material, essential information might be contributed by: experts in the specific area selected; comprehensive rehabilitation experts; professional translators and lexicographers; medical writers and editors; and artists, draftsmen, and photographers. As the rapid growth of knowledge regarding all aspects of rehabilitation has resulted in a proliferation of information from a variety of sources, improved methods for documenting, processing, and rapidly retrieving this data have become more and more urgent. In developing new rehabilitation terminologies or in making a selection from among several already familiar terms, attention should also be given to the probability of the eventual use of these terms in a computerized data processing system.

Language. Some general agreement must be reached on the level of language usage and the choice of specific languages to be included within a terminology. In choosing between synonyms derived from different roots, consideration should be given to the particular audience which will be using the terminology. Consideration must also be given to the urgent need which exists for references to assist in producing informational materials of use in the developing areas of the world where rehabilitation services are most rudimentary.

Bibliographies of Multi-Lingual Texts and Articles. Up-to-date information about pertinent texts and articles written in one national language and translated into one or more foreign languages would serve as an extremely valuable resource both to the specific professional groups collecting such material and to groups developing multi-lingual references. One international organization, the World Federation for Occupational Therapy, has already established a procedure for its national member associations to do this, and others should be encouraged to take similar action.

Suggested procedures for approaching the compilation of glossaries and full details of the findings, conclusions, and recommendations are included in the complete report of the study. The report will be published separately and will be available from the ISRD Secretariat.

CHAPTER VIII -- SUMMARY

Purpose

The International Research Development Project was designed to study and evaluate the international need for improved rehabilitation services in both the economically developed and developing areas of the world and to assess the structures and functions of international organizations which best assist in meeting these needs.

Methodology

In implementation of the purposes of the Project, the ISRD has undertaken a number of activities. The organization of international programs and the function of international meetings have been examined through analyses of the ISRD's experience in the operation of its program, through the Conference on the Organization of International Programs and the Eleventh World Congresss Evaluation. Methods for effecting greater direct exchange of rehabilitation information have been explored through the International Research Referral Service and the study of Multilingual Rehabilitation Terminology References. Procedures for applying rehabilitation techniques to areas where trained personnel and local resources are severely limited have been considered at the Expert Meeting on the Assessment of Levels of Service Related to Available Resources while many rehabilitation programs and facilities in urgent need of improvement and assistance have been identified through the International Project Information Service.

Findings and Implications

The problems of international rehabilitation development have been studied through various evaluations, conferences, and services conducted with support from the International Research Development Project. It is recognized that multidisciplinary cooperation in the rehabilitation field internationally is intrinsically a complex process and so it is not possible to formulate simple or static conclusions on the basis of the findings which have emerged from these activities. Rather, the results imply a variety of procedures for advancing the level of international program organization and furthering the application of rehabilitation expertise and technology in all parts of the world and suggest areas for further study.

Organization of International Programs. In order to examine methods of organizing international groups for meaningful cooperation, the governing bodies of the ISRD made a preliminary analysis of the Society's current organizational structure and the problems associated with it. The results of the analysis were summarized by the Secretariat and served as documentation for an International Conference on the Organization of International Programs convened in Belgium in April, 1969. This expert meeting was attended by the chairmen of the ISRD's various committees and commissions or their representatives, members of the ISRD Executive Committee, and invited individuals with competence in this field. The findings of the meeting and the analyses of the ISRD's activities indicate that:

a. International organizations are of definite value for bringing together people from all parts of the world with similar interests. It is necessary to be certain that there is a potential for genuinely valuable activity in addition to this reunion function which, although of importance, may be achieved through other methods such as periodic ad hoc events organized by a parent or other organization.

b. The impulse for individuals and institutions to join international organizations to identify with those of similar interests is strong. Experience suggests, however, that unless there are adequate resources for an active secretariat and program, real accomplishment will be minimal--a fact often obscured by the personal gratification gained by individuals from the "reunion" experience.

c. Experience with a variety of special interest groups operating within a single international organization suggests that the proliferation of such groups tends to make the coordination of progress among professions and partisans of specific disability groups more difficult. It is likely that generalizing institutions, if sufficiently aware of the problems of the special interests, can provide a more reliable mechanism for such coordination of planning and action.

International Project Information Service. The International Project Information Service was created to provide validated information which would guide planning for the further development of rehabilitation services. It consists of a central file of data on the problems of disability and existing and proposed rehabilitation projects in various countries. While devising procedures for the operation and maintenance of the Service, it has been found that:

a. Many inter-governmental, international, and national organizations active in the international rehabilitation field recognize the importance of basing rehabilitation service planning

on the most comprehensive information available about local, national, and regional rehabilitation resources in the medical, social, vocational, and educational fields to ensure that limited resources may be directed into projects and programs of the highest priority.

b. The number of organizations initiating activity internationally without access to such comprehensive information and which, therefore, are unable to coordinate their activities with other ongoing projects is rapidly increasing.

c. While a number of national and international, voluntary and governmental bodies receive much information of the type being considered, no one has an adequate system for the verification, storage and retrieval of such data.

d. With the amount of information received regularly by the ISRD, supplemented by data provided by cooperating institutions and individuals, it is possible to assemble reasonably accurate and complete profiles of the disability and rehabilitation situation in most countries and distribute this information to concerned organizations and groups.

e. The ISRD and other bodies need and can make use of such profiles, and of various specific details from such profiles, in planning their programs and technical assistance, in seeking cooperation and avoiding duplication, and in interpreting to their supporters and constituencies the quantity and quality of the problems being faced.

f. If it were possible to gather and maintain on a reasonably current basis adequate data about the situation in a large number of countries, especially in the developing areas, it would be possible to produce analyses of the needs on regional and global bases that should assist all concerned agencies in interpretation, planning, action and coordination.

g. A sharply expanded, but still relatively modest operation by the ISRD for a period of not more than three years would make possible the assembly of adequate information about the rehabilitation situation in most countries and could provide the comprehensive information about available resources which is essential to proper rehabilitation service planning. Subsequent maintenance of such a file would be a much simpler and more modest operation.

International Research Referral Service. The International Research Referral Service was established by the World Commission on Research in Rehabilitation and has been strengthened and expanded under the Project. The Service fosters the exchange of information

about rehabilitation-related projects in process by distributing brief summaries of current research to researchers and research-supporting organizations in all parts of the world. Evaluation of and experience with the Service has shown that:

a. There is a definite need for a service that can provide ongoing information about research being conducted in the same or similar fields in different parts of the world. Such a service is of particular assistance to researchers when they are planning their project design. It helps to reduce duplication of efforts and accelerate the practical application of research findings.

b. With increased attention to the Research Referral Service, it has been possible to stimulate considerable interest among researchers with a resultant improvement in the worldwide exchange of research information.

c. Distribution of research project summaries in subject groups, publication of brief research project descriptions, and direct invitations to researchers to participate in the Service, have all been useful techniques in the expansion of the Research Referral Service.

d. Almost 40% of the researchers and institutions contacted internationally in 43 countries have indicated their desire to participate in the Referral Service. Fewer than 10%, however, have actively responded by contributing summaries of their latest projects for distribution.

e. A desire on the part of some individuals to withhold information about research projects prior to publication may in part be contributing to the small percentage of researchers who actively contribute to the Referral Service. Preliminary pre-publication research information is of value in reducing the time delay involved in formal publication and is usually of great assistance to researchers and practitioners in countries without ready access to current professional periodicals. It is therefore of great importance that new methods be developed to encourage researchers to share information about their current ongoing projects.

f. The present circulation and scope of the Research Referral Service only partially reflects the breadth and quality of rehabilitation-related research being conducted internationally. In order that the Service may be of maximum benefit to researchers and practitioners alike, it must encompass more information about international research in progress. This may best be achieved by contacting greater numbers of researchers and possibly research supporting organizations directly to inform them about the availability of the Service, its purposes and operation, and elicit their

cooperation and participation.

Assessment of Levels of Service Related to Available Resources. As all available estimates of the extent of the problems of disabled persons, especially in the newly developing countries, indicate that the present and potentially available personnel and services will be incapable of coping with those problems using present approaches towards the delivery of rehabilitation services, the ISRD convened a meeting of experts under the aegis of the Project to consider means of expediting society's capacity to provide rehabilitation assistance. The participants were chosen because of their individual and organizational experience in organizing and developing rehabilitation programs. During the meeting, they agreed that:

a. The quantitative disparity, both present and predictable, between needs and services is so great that there is strong reason to support the validity of seeking methods of assistance that will be less demanding on the time of highly trained personnel and other scarce resources.

b. It is possible to identify different levels of service in the educational, medical, social, and vocational aspects of rehabilitation which range from basic and essential services to more advanced services.

c. Having ascertained the levels of rehabilitation service, it is possible to relate the necessary service functions to the qualifications of personnel and suggest functions usually performed by highly qualified professionals that can, with proper organization and supervision, be performed by personnel who are less completely trained but whose competence is adequate for the purpose.

d. It is also possible to reach agreement on criteria for the training and employment of auxiliary personnel to perform, with adequate supervision, routine tasks in order to free highly trained professionals for tasks demanding their competence.

e. Patterns of progressive training may be created through formal education and practical experience which will provide auxiliary personnel while giving interested and competent individuals the opportunity to build on auxiliary experience and formal education and achieve full professional standing.

f. Additional study is needed to devise adaptations of rehabilitation techniques which fit locally available resources. As no nation has yet achieved completely satisfactory services for all of its disabled population, innovative procedures and techniques in the delivery of rehabilitation services should justly be the concern

of personnel in all parts of the world, even though gross inadequacies in service may be particularly apparent in economically developing areas.

g. The imposition of traditional and accepted patterns of service in areas newly developing rehabilitation facilities and programs may not only be inappropriate in relation to available resources but may also hinder the development of new patterns of service which might offer long-range solutions to the world-wide problem of disability.

h. Planning of rehabilitation services should be based on the most comprehensive information available to identify urgent needs and the extent of available resources. Priority should be given to those programs which will give clear and significant results and may be most enthusiastically supported by the local community and government.

Eleventh World Congress Evaluation. During the ISRD Eleventh World Congress, an evaluation of the function and effectiveness of a large international meeting of this type was conducted. The results of the evaluation suggest that:

a. A general world congress, designed for all categories of professional and lay persons, accomplishes the following:

---all concerned gain a sense of identity with the general cause.
---participants who apply themselves to contacting organizational representatives or other participants with similar interests may establish useful contacts and renew previous contacts which can be personally satisfying and are sometimes professionally valuable.
---specific professional advantage is gained by members of special interest groups when well-planned and relevant meetings of those with similar interests are incorporated into the congress program.

b. With the conventional patterns of congress organization, certain claimed purposes appear to be realized in very limited degrees:

---efforts to present the problems of the various professions and interest groups against a wider horizon of rehabilitation or of society at large have not elicited widespread interest or participation. For example, carefully prepared sessions with highly qualified experts on such subjects as "The Economic and Social Value of Rehabilitation" and "Rehabilitation in the Developing Countries" have not attracted interest.
---efforts to convey technical information regarding recent advances in rehabilitation on a level of potential interest to all

participants often result in meetings which are too general or superficial in nature to be of significance to participants seeking such information.

c. Taking into account the above findings together with those emerging from the study of methods of organization of international action, it appears that future congresses should be planned so that special interest groups will have better and more opportunity to hold well planned meetings in the framework of the general conference and that new ingenuity is needed in planning techniques that will interest and involve participants in consideration of obviously important questions of inter-disciplinary collaboration, the relation of rehabilitation programs to the more general problems of society and cooperation to expedite the development of services in the newly emerging areas.

Multi-Lingual Rehabilitation Terminology References. The ISRD, because of its deep involvement in international communications and concern about the barriers to understanding within and between disciplines and countries, has long been aware of the need for agreement on basic rehabilitation terminology in major languages. At its Eleventh World Congress, meetings on this subject aroused such general interest that a special study was undertaken under the Project to identify available multi-lingual rehabilitation terminology references and suggest directions for future cooperative efforts. Through this study, it was learned that:

a. There is intense interest in the problems of multi-lingual communication and many varied efforts have been made in most rehabilitation-related subjects to devise terminology references of use to specific groups.

b. Existing multi-lingual rehabilitation terminology references have generally not been completely satisfactory owing to problems such as translation errors, controversial choice of terminology and restricted choice of languages.

c. A range of different types of terminology references are needed to serve the variety of communication situations inherent in the rehabilitation process, e.g., communication between the practitioner and patient, communication among organizations sponsoring rehabilitation programs, and communication among rehabilitation personnel in all parts of the world.

d. The need for terminology manuals to improve communications at all levels in the rehabilitation process internationally will continue to grow as more national languages are used and technical advances require the development of additional concepts and terms. An immediate need exists for additional simple pocket-size terminology

guides in different rehabilitation-related specialties for use in clinical situations. Terminology references in fields including special education, occupational therapy, vocational rehabilitation, and speech and hearing, would be particularly helpful.

e. Any group wishing to undertake the preparation of simple terminology guides should be encouraged to do so after consulting with individuals and organizations experienced in terminology development and reviewing the status of already completed and planned projects.

f. More sophisticated references are already needed and will continue to be in demand to meet professional and organizational needs in international rehabilitation communication. It is essential that uniform use of terminology be achieved within the various rehabilitation disciplines monolingually if the process of valid glossary and terminology development is to be extended.

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APPENDIX A - VIEWS ON THE LEPROSY COMMITTEE OF THE I.S.R.D.

The Committee on Leprosy Rehabilitation has been in existence since 1961 and the outlook on leprosy and leprosy rehabilitation has changed greatly during this period. A decade ago leprosy was the care of leprosy doctors and workers. Today it has been accepted as a part of the many medical and rehabilitation problems of the world. There may be some reservations in actual implementation but the principle has been generally accepted. This committee has played its part with many other organizations in achieving this remarkable change in outlook.

The sacrifice and dedication of the leprosy workers and the progress achieved by them in the past, in the face of great opposition, must be commended. The change in world outlook on leprosy during the last decade needs a corresponding change in the outlook of those who work in this field. While their approach is undoubtedly changing it is not in keeping with the new outlook on this disease.

Surgery and rehabilitation have during the short span of 20 years helped to focus attention on leprosy, yet we all realize this is by no means the answer to the problem. An objective outlook also shows us the impossibility of ever eradicating or controlling the disease on a world-wide basis with the measures at our command today. DDS, a reasonably potent weapon in our armamentation, provides the theoretical means of control. Yet we all know the almost insuperable task of delivering the drug to the patients over a prolonged period of time.

The major effort and money at this stage are being directed to improving the orthodox methods of surgery, survey, education and treatment. Examples of successful implementation are cited. These are unfortunately solitary islands of concentrated effort by a few dedicated men with the necessary financial assistance. It is doubtful if this can be repeated on a world-wide basis.

A more hopeful approach lies in deepening our knowledge about this disease and overcoming the ignorance among the medical and lay public. The immediate need in leprosy is the necessity for the education and active involvement of the medical profession, members of other professions and of the lay public and not in merely perfecting the methods and techniques of yesterday, whether this be surgery, medicine or DDS treatment. It should be the aim of leprosy work to lose identity among the infinitely greater volume of general medicine, general rehabilitation and general publicity. This separation was unavoidable in the past but will be unnecessary tomorrow. We in this period of transition must hasten this change even at the expense of losing our identity. Today there is not the old resistance to the acceptance of

the disease among research workers or the lay public. (The medical profession is probably the most orthodox and resistant group.) It is not for us to expect the research worker and the public to approach the problems of leprosy. It is for us to take the problems to them. Having interested them we should withdraw, or preferably merge with them so that we may act as watch dogs from within. The enormous human and financial resources of the scientific world and of the community in general cannot be matched by leprosy. The present limited resources should be used to the greatest advantage in inducing this change or merger.

The I.S.R.D. Leprosy Committee has managed to focus attention on the problem of leprosy and has helped to start programmes of surgical rehabilitation training. I believe this phase is now over. If the Committee must justify its continuation it must radically change its objectives. The Committee can play an important role for the next few years if it attempts to integrate leprosy rehabilitation with the general and other specialised rehabilitation programmes of I.S.R.D., especially in the field of education and research. During the early phase, the techniques of rehabilitation established for other conditions may, with advantage, be applied to the problems of leprosy, and in doing so come closely in contact with the other disciplines and interest them in leprosy as one of the new problems in rehabilitation. If this is pursued to its logical end together with the simultaneous merger of other aspects of leprosy in the mainstream of science and the community, then it may be possible to discontinue this Committee. I believe that in this interim period of about 10 years this Committee, if it reorientates its aims, can with its own status and the influence of the I.S.R.D. play a most important role not only in general education but also in stimulating universities and other centres of general scientific studies to accept the problems of leprosy for enquiry.

APPENDIX B - ORGANIZATION OF INTERNATIONAL PROGRAMS: ADVISORY MEETING ON FUTURE POLICY CONCERNING COMMITTEES AND COMMISSIONS -- ANALYSIS OF THE PROBLEM

Introduction

1. This document is an effort to summarize the problems which have been encountered by the Secretariat in connection with the operation of committees and commissions as they have been organized and related to the ISRD in the past. It should be emphasized from the outset that no unfavorable criticism of any individual or organization is intended. Whatever shortcomings may have been experienced have been a consequence of the "trial and error" process required for the development of new international activity and of the absence of specific agreed policies. If the present effort to establish effective policy for the future is to succeed, it must take into account the experiences of the past and particularly the difficulties which have been encountered.

2. No generally applicable principle has been evolved concerning the use of the terms "committee" or "commission" and there is not in the present situation any overall distinction between the two terms as used in the titles of the groups.

3. An analysis of the functioning of committees and commissions must be based on an agreed understanding as to their relationship to the ISRD and as to the lines of responsibility and authority involved. The Constitution of the ISRD provides:

a. That the fundamental governing and policy-making body is the Assembly, composed of representatives designated by the Affiliated National Organizations.

b. That the Assembly elects a Council to manage the affairs of the Society between meetings of the Assembly.

c. That the "Council may establish Scientific and Technical Committees and Commissions which shall serve to expand and strengthen the program activities of the International Society and to advise the Society on matters pertaining to particular fields of competence."

d. That the Council appoints a Secretary General who "shall have executive responsibility for the affairs of the Society."

4. It may therefore be concluded that the present provisions of the Constitution envisage Committees and Commissions which are established by and responsible to the Council. They are an integral part

of the structure of the ISRD, and their program, finance and other functions are the responsibility of the governing bodies of the ISRD. The implementation of that responsibility is the function of the Secretary General.

5. It is recognized that all Committees and Commissions have not been operated in accordance with the above principles, and that facilities have not been available to enable the Secretary General to function as the constitutional arrangements prescribe. Nevertheless, an understanding of the problems must be based on an understanding of the structural basis of the organization, which can of course be modified if it is determined that change is necessary to obtain maximum effectiveness.

6. Several examinations of this problem have been prepared in the past and have contributed greatly to present thinking. To avoid an excess of documentation, they have not been reproduced, but much of the thought in them has been drawn upon for the present analysis.

The Principal Problems

7. Communications: Underlying most of the other problems experienced in the operations of Committees and Commissions is the difficulty of adequate communications. This is of course true of all aspects of the work of an international organization, but the difficulties have been especially pronounced in connection with Committees and Commissions. Distance, differences of language and of conceptions, insufficient secretariat facilities, lack of funds for frequent meetings; these have all contributed to inadequate communications which in turn have played an important role in the other problems experienced.

8. Formation and Coordination of Policy: Until now there has been no agreed procedure for the establishment of ISRD policy on the questions of substance being dealt with by Committees and Commissions, and no arrangements for the coordination of policy action among the various Committees and Commissions or between them and the Secretariat, the Council and Assembly. As a consequence, there have been instances of the following:

a. The officers of a Committee or Commission have established and presented through their program and to official bodies a policy or policies which have never been considered by the governing bodies of the ISRD.

b. The Secretariat, which has day-to-day contact with the United Nations and other official bodies, has discovered that the officers of Committees and Commissions have presented to those bodies statements of policy of which the Secretariat and governing bodies have no knowledge.

c. The Secretariat, in its day-to-day dealings with representatives of the United Nations and other organizations and in its arrangements for representation at and participation in meetings of such bodies, has on some occasions expressed or supported policy positions not previously considered by the relevant Committees or Commissions.

9. Program: There has been no generally accepted procedure for the coordinated planning of program activities by Committees and Commissions. Some have sought the assistance of the Secretariat and the approval of the Council for proposed activities; others have not.

a. On some occasions, the Secretary General has learned from outside sources of program proposals which have been initiated by the officers of Committees and Commissions without any prior consultation or coordination with the Secretariat.

b. On some occasions, the Secretariat has proposed or negotiated about program proposals without prior consultation with the relevant Committees or Commissions.

10. Finance: Experience to date shows a direct relationship between the facilities for financing the work of Committees and Commissions and the nature of the subsequent activity. Several categories of result have been observed:

a. In some cases, the ISRD has obtained special grants to finance the work of a Committee or Commission, and has thus been able to provide the Secretariat for the body in question. As would be anticipated, this situation has produced a minimum of problems.

b. In some cases, the ISRD has received earmarked contributions for the work of a specific Committee or Commission. These have been sufficient to support partial Secretariat services, consultant travel and other minor items, but have not been sufficient for a full operating budget. The results in these cases have been influenced by other complicating factors, but have not produced full value for the money spent.

c. In some cases, Committees or Commissions have obtained their principal financial support directly from sources outside the ISRD. The ISRD has had no direct role in obtaining the funds, no part in deciding on the allocation of the funds and limited if any possibility of supervising the activity so financed. Obviously, this situation leads to a degree of independence on the part of the Committee or Commission concerned, which is not consistent with the present constitutional provisions.

d. In some cases no significant funds have been available

for the work of some Committees and Commissions. Their functions, consequently, have been limited to meetings on the occasion of World Congresses and to sporadic exchanges of correspondence. Communications and coordination have been weak, but there have not been major problems.

11. Membership: The composition of the Committees and Commissions, whether of organizations or of individuals, has been to some degree in conflict with the statutory structure of the ISRD. While efforts have been made to obtain the agreement of Affiliated National Organizations concerning participants from their countries, the results have not always been harmonious.

12. World Congresses: The Constitution provides that the program of a World Congress shall be the responsibility of the Congress Organizing Committee in the host country. The standard Memorandum of Agreement provides that the advice of the Affiliated National Organizations and of the relevant Committees and Commissions shall be sought. In some cases, the officers of Committees and Commissions have assumed this to mean that they have an absolute right to conceive, plan and arrange some sessions of the Congress. It is not possible for the Organizing Committee to release control in this way if it is to preserve a maximum balance and coordination in the overall program.

13. Administration: Over the years, the various Committees and Commissions have evolved structures and memberships which vary considerably. Some are in a position to maintain their own records; some are not. But, in any case, it is necessary for the ISRD Secretariat to maintain accurate mailing lists and other basic information about the composition and activity of each Committee and Commission. In the present complicated situation, the required administrative effort is out of all proportion to the benefits obtained.

14. Roles of Individuals: Much activity that has been credited to the Committees and Commissions has been in fact the product of initiative and effort by a secretariat, either in the ISRD or elsewhere, or of one or more individuals acting in keeping with their individual experience, competence and contacts. It is necessary, therefore, to be pragmatic in determining which activities in fact require a committee or commission, which can be performed by a secretariat drawing upon the services of appropriate individuals, and which can be performed by individual consultants.

Conclusion

15. It is hoped that the above information will suggest some of the specific problems being encountered in connection with the operation of Committees and Commissions. Certain difficulties will always

persist in the management of a widespread international voluntary organization, but it is believed that the complications of the present situation go beyond all reasonable bounds, and that policies should be established for the future which will reduce these problems to a minimum and insure that effort is directed to the accomplishment of the agreed objectives of the ISRD.

APPENDIX C - ORGANIZATION OF INTERNATIONAL PROGRAMS: ADVISORY MEETING ON FUTURE POLICY CONCERNING COMMITTEES AND COMMISSIONS -- IMPLEMENTATION OF ISRD FUNCTIONS

Introduction

1. It is the purpose of the present paper to describe the functions which the International Society for Rehabilitation of the Disabled has assumed in the responsibility to perform and to examine the means available for their performance. It is hoped that this information will serve as a basis for a discussion of the role of Committees and Commissions in the implementation of the program of the ISRD and of the policies which should govern the operations of such bodies.

Functions of the ISRD

2. Article II of the ISRD Constitution lists the purposes of the organization. From these purposes it may be derived that the functions which the Society intends to perform are the following:

a. To bring about an international exchange of information.

b. To organize international meetings.

c. To encourage research.

d. To encourage the formation and development of organizations working for the disabled.

e. To assist the development of programs for the disabled.

f. To cooperate with other international organizations.

g. To stimulate and assist in the development of suitable legislation in the various countries.

h. To raise funds for the ISRD.

i. To provide international services and technical assistance.

3. In addition, it may be assumed that the organization has been formed and maintained with certain more general objectives in mind. These include:

a. To provide an international institution which will symbolize, defend and represent the best interests of the world-wide

rehabilitation fraternity, including the disabled, the professional workers and the volunteer participants.

b. To provide an international focal point for the participation and affiliation of organizations and individuals interested in this field and to give them opportunities for international activity and identity.

c. To eliminate when appropriate the need for a proliferation of special interest groups and to provide, as possible, channels for coordinated effort among all interested organizations.

Means of Implementation

4. From the experience of the ISRD and of other international organizations, it may be suggested that the means available for the implementation of the agreed purposes are primarily the following:

a. The preparation and distribution of publications, both of the ISRD and of other organizations, with special emphasis on the need to overcome barriers of language, custom and distance.

b. The preparation and distribution of audio-visual materials with the same emphasis as for publications.

c. Consultations among organizations as, for example, the opportunities provided by the Society's consultative relationships with the United Nations, WHO, UNESCO, etc., to participate in and present recommendations to the policy-making bodies of those organizations. Informal consultations among these and other organizations are conducted continuously by their respective secretariats and occasionally by their officers.

d. The assignment of qualified experts to assist in the implementation of certain of the agreed functions.

e. The provision of training opportunities for professional, auxiliary, organizational and voluntary personnel through fellowships, training courses, demonstration projects, etc.

f. The exchanges of correspondence and visits which take place in the normal course of operating an organization and which in fact are the vehicles for much exchange of information, provision of guidance and advice, encouragement of useful activity, development of plans and solutions of problems.

g. Grants of funds which will be used for purposes other than those included in other items on this list, such purposes of course being within the functions of the ISRD.

h. The provision of supplies and equipment needed for the establishment or improvement of rehabilitation services.

5. A diagram showing the relevance of these various means to the agreed functions of the ISRD is presented at the end of the appendix.

Structure for Implementation

6. Drawing again upon the experience of the ISRD and of other international organizations, it may be suggested that there are a number of methods of structuring the available personnel, resources and energy to perform the agreed activities. Some of these are:

a. A secretariat, acting on the instructions of the governing bodies and obtaining advice from qualified individuals on an individual basis.

b. The use of consultants, honorary or compensated, to work in conjunction with the secretariat or in direct relationship with a governing body.

c. Single meetings with groups of qualified individuals to provide advice on a specific matter.

d. Ad hoc committees formed for a limited period of time to perform a specific function.

e. Standing committees formed on a permanent basis to perform defined functions in connection with a secretariat or a governing body.

f. Organic committees created as an integral part of the policy-making structure of an organization.

7. A review of the experience of ISRD Committees and Commissions will show that, while they are essentially formed as standing committees (Para. 6 e.), their performance has in fact frequently been more appropriate for one of the other structural methods. Future policy should be based on a realistic evaluation of this question so that the method chosen for the implementation of any purpose will be that most likely to produce maximum results in the most economical and efficient way.

Past Experience

8. There have of course been many varieties of experience associated with past efforts to implement the program of the ISRD and to make effective use of Committees and Commissions for this purpose. Being aware of the limitations of generalization about this experience, it may nevertheless facilitate consideration of the matter if a general evaluation is made of these past efforts.

9. Publications

a. Two of the Committees or Commissions have as a principal function the publication of periodicals. This is accomplished with a secretariat not under the direction or control of the governing bodies of the ISRD. The ISRD obtains and provides a part of the financial support for these publications.

b. Some of the Committees and Commissions have been helpful in providing suggestions as to useful material for distribution. The reports of some of their meetings have been published and distributed. In some cases the existence of a Committee has provided a point of identity for a publication project.

c. The effectiveness of each of the above actions has been dependent on the availability of a secretariat, either at ISRD headquarters or elsewhere.

10. Audio-Visual

a. Apart from the International Rehabilitation Film Library, operated by the ISRD Secretariat, and the film program at Congresses, the Society has not done much in this field.

11. Meetings

a. The organization of meetings, seminars and workshops has been one of the principal activities of the Committees and Commissions. In most cases, the availability of a secretariat, either the ISRD's or another, has been essential and the principal functions of the Committee or Commission as such have been to provide the formality of an organizing institution, to give advice as to program and participation and to supply continuity.

b. In connection with the organization of World Congresses, the officers of Committees and Commissions have been helpful in providing suggestions as to program and participants. This assistance, however, has come mainly from individuals with experience and knowledge of their field who were officers of Committees and Commissions rather than from the groups as such.

12. Consultations

The day-to-day consultations are carried out in the main by the Secretariat. When possible, arrangements are made to designate officers of appropriate Committees or Commissions to perform this function. It is essestial that the appointed individual act as the representative of the ISRD and not just of a Committee or Commission since it is the ISRD to which the official status has been granted.

13. Experts

a. Individuals active in ISRD Committees and Commissions have frequently served as international experts acting for the Society and for other organizations. They are chosen for their individual competence and availability, however, and not because of their role in the Committee or Commission.

b. Advice as to the identification and selection of experts can be obtained from officials of Committees and Commissions, but it is not practical to seek such advice from the group.

14. Training

In some cases, training projects have been carried out under the formal auspices or with the formal cooperation of ISRD Committees or Commissions. In fact, however, the actual work involved has been done and the connection of the ISRD Committee or Commission has been a product of the expertise and availability of one or two individuals.

15. Correspondence and Visits

These functions have been carried out extensively by persons associated with Committees and Commissions, by officers of the ISRD and by the Secretariat, and it is not possible to generalize about the results except to point out that the long range impact of many such contacts is lost because the substance is frequently not transmitted to the ISRD Secretariat to become available for planning purposes to assist others.

16. Grants

Limitations of funds have prevented the Society from engaging in a significant grant program until now. A great majority of the grants it has been able to make have gone to the Committees and Comissions for their operations.

17. Supplies and Equipment

Experience to date has been too limited to justify analysis.

18. General Objectives

It will be recalled that certain general objectives of the ISRD were suggested in Para. 3 above. It seems likely that the existence of the various Committees and Commissions has had some importance in this connection. It has helped create the image of a comprehensive organization, it has given a number of individuals position

and identity, and it has had an effect -- as yet unevaluated -- on the proliferation of special interest groups.

19. A summary of the past experience may be presented by the following points:

a. The existence of Committees and Commissions has helped establish the image of the ISRD, has identified and attracted a number of competent individuals and given them roles to play, and has influenced the proliferation of organizations.

b. Committees and Commissions which have undertaken specific program activity have succeeded only to the extent they have had adequate secretariat services and financing. It is likely that, with adequate secretariat services and financing, most of these activities could have been carried out whether or not there was a Committee or Commission.

c. Competent and available individuals associated with the Committees and Commissions have been most helpful in advisory and functional roles.

	Publi-cations	Audio-Visual	Meetings	Consul-tations	Experts	Training	Corres-pondence and Visits	Grants	Supplies & Equip-ment
Exchange of Information	X	X	X	X	X	X	X		
Organize Meetings			X	X			X	X	
Encourage Research	X		X	X			X	X	
Organization Development	X		X	X	X	X	X	X	
Program Development	X	X	X	X	X	X	X	X	X
Cooperate with International Organizations	X		X	X			X		
Legislation	X		X	X	X	X	X		
Fund Raising for ISRD	X		X	X	X		X		
International Services & Technical Assistance				X	X	X	X	X	X

APPENDIX D - MAJOR REHABILITATION SERVICES IN NIGERIA

INTRODUCTION

The Federation of Nigeria lies on the west coast of Africa between Dahomey and Cameroon, encompassing about 600 miles of coastline. Fifty-seven and one-half million people, almost one-fifth of the population of the entire African continent, live within the country's 356,669 square miles -- an area which is approximately one-tenth the size of the United States. Nigeria was divided into four main regions which were realigned as twelve states in 1968 prior to the end of the recent civil hostilities. Main cities within each of the former regions include: Ibadan and Abeokuta (Western Region); Benin (Mid-Western Region); Enugu, Port Harcourt (Eastern Region); Kaduna, Zaria, Maiduguri, Kano, Katsina (Northern Region), and the Federal Territory of Lagos which is in the western section of the country. Almost 250 tribal and linguistic groups live throughout the country including the Hausas in the North, the Ibos in the East and the Yorubas in the West. About one-half of the population lives within the Northern Region alone. Islam is the principal religion in the Northern Region and among the Yorubas.

Two major railroad lines and a network of all-weather roads connect the regions. Internal airline transportation is also available. The economy is mainly agricultural with its principal exports of cocoa, palm products, groundnuts, rubber and crude petroleum.

Education services at the primary, secondary, and university levels have all been expanding in recent years. As of 1963, more than 3 million children of the estimated population of 26.5 million children were attending primary schools. Free primary education had been introduced in the Western Provinces and in Lagos; however, limited education fees were still being collected in the Eastern region at that time. A major project to improve primary education in the Northern region has been initiated with UNICEF assistance in order to enroll at least 28% of six to seven year old children in schools by 1970. UNICEF has also supported the development of modern six year primary schools in the mid-western area to replace secondary schools in that region. In 1966 more than 250 teacher training colleges were training over 32,000 teachers.

Nigeria has about 263 hospitals with a total of 18,537 beds. More than 2,500 beds are available in maternity homes, and services are offered in 91 health centres throughout the country. There are an estimated 31,700 people per physician. The University Teaching Hospital at Ibadan, and the Lagos Teaching Hospital both concentrate on training doctors, nurses, and other medical staff.

ORTHOPEDIC AND NEUROLOGICAL DISORDERS

Programs with Government Support

The Royal Orthopedic Hospital, Igbobi, Lagos, has a physical therapy department staffed by two qualified therapists and seven locally trained assistants. The department was established in 1945 by two English physical therapists who initially trained twenty assistants. The staff reports treating up to sixty patients a day. There is also an occupational therapy department in the hospital which is staffed by two untrained craft teachers. The occupational therapist assigned to the General Hospital may be used part-time in this department. The World Rehabilitation Fund (WRF) provided training for a physiatrist from this institution between 1959 and 1962.

The Centre for Spastic Children, Igbobi, Lagos, is situated in a building provided by the Ministry of Health on the grounds of the Royal Orthopedic Hospital. Equipment has been provided with voluntary support from organizations such as the Red Cross. Fourteen of the 40 children registered attend the Centre regularly for treatment and schooling. The staff is composed of one full-time physical therapist, one part-time physical therapist who is shared with the Orthopedic Hospital, teachers from the Orthopedic Hospital School and two social workers. Approximately 500 children have been evaluated through this program. In 1968 a World Health Organization (WHO) physical therapist worked in the Centre.

Two other hospitals in Lagos maintain rehabilitation facilities. The General Hospital operates, under the supervision of a qualified Physical Medicine Director, a small well equipped physical therapy department staffed by three physical therapists, one of whom was qualified abroad. A qualified occupational therapist is soon to establish an occupational therapy section within the department. The University Medical College Hospital is a new teaching hospital containing a physical therapy department staffed by two qualified physical therapists. A physical therapist from the Voluntary Service Overseas (U.K.) assisted in this department in 1967. After a study tour by the Secretary General of the International Bureau for Epilepsy in 1967, the Medical College Hospital conducted a preliminary survey of epilepsy patients and social attitudes facing them. The Institute of Child Health affiliated with the Hospital refers many patients to the physical therapy department and other appropriate treatment centers. The Institute reports evaluating an average of 100 children a month and has received equipment and support from the Van Leer Foundation. The Institute has sent a physician overseas to study rehabilitation in the hope of establishing a unit of its own for handicapped children.

In addition to these centers, there is one Prosthetics and Orthotics Workshop in Lagos, staffed by three technicians trained abroad

who report producing 150 prostheses and 4,000 braces per year. A primary school for about thirty physically handicapped children, the Atunda-Olu School, P.O.B. 257, 2 Adamu Orisa Street, Surulere, Lagos, is staffed by three teachers and a headmistress. The school was established in 1965 by the Ministry of Education and several voluntary societies. The government maintains the school while other support continues to be provided by voluntary organizations such as the Church Missionary Society.

Major rehabilitation facilities are also located in Ibadan. The University College Hospital, Ibadan, is a 500 bed teaching facility with a fully equipped physical therapy department staffed by eleven trained physical therapists. It has been reported that about 130 new poliomyelitis cases are referred for physical therapy each year. In 1963, 54,000 persons in Ibadan were vaccinated against this disease using Type II monovalent vaccine initially, followed by administration of Types I and III monovalent vaccines four weeks later. The effects of vaccination were reported to be discouraging as only 65%, 21% and 48% conversion rates were shown for each Type respectively in vaccinated patients sampled afterwards. The occupational therapy department is staffed by three trained occupational therapists and utilizes local materials in therapy activities. A school for primary and secondary grades is also maintained.

An Orthopedic Rehabilitation Centre was established in Eleiyele, Ibadan in 1962 to serve amputees. It is operated in conjunction with the Prosthetics Workshop which is staffed by two qualified prosthetists and thirty locally trained assistants. Production of an average of 200 appliances per year has been reported. The Adeoyo Hospital physical therapy department was established in 1950 within this 200 bed facility. By 1968 it was staffed by one physical therapist. Expansion of this department within the new General Hospital being constructed on the outskirts of Ibadan is planned. The Abeokuta Hospital located between Ibadan and Lagos, has a small physical therapy department which lacks equipment. It is staffed by one qualified physical therapist and an assistant who reports treating about twenty patients a day. This physical therapist also consults with Lantoro and Aro Mental Hospitals.

Rudimentary physical therapy programs and orthopedic facilities have also been reported in Dalla Hospital, Kano (Northern Region) and Enugu General Hospital, Enugu (Eastern Region).

Programs with International Support

An inter-agency project to develop a comprehensive and coordinated national rehabilitation program may be developed with support from the United Nations Rehabilitation Unit, ILO, WHO, UNESCO, UNICEF and

interested non-governmental organizations such as the ISRD and the WRF. The possibility of sending a short-term ILO expert to assess problems and assist in planning the development of services is being considered. The grounds of the Royal Orthopedic Hospital, Lagos, may serve as the location of the project. UNICEF reports having prepared rehabilitation equipment for distribution to hospitals, health centers and schools in the Eastern Region. The WRF in cooperation with the African-American Institute, has considered offering a short-term intensive training course in prosthetics within the country.

The International Committee of the Red Cross opened an artificial limb workshop at Atta (Eastern Region) and is supporting the work of a team of Swiss physicians and nurses conducting orthopedic surgery at Aboh in the same region. In the past, the United Nations Rehabilitation Unit and the ILO have provided fellowships to several government officials and rehabilitation personnel for study tours. One survey mission of vocational rehabilitation program development was conducted by the ILO in 1966.

See Also:

National Fund for Research into Poliomyelitis and Other Crippling Diseases.

Voluntary Service Overseas

World Health Organization

Listed Under:

School of Physiotherapy

University Medical College Hospital.

Centre for Spastic Children

Programs with Voluntary Support

There are four Cheshire Homes for physically and mentally handicapped children: the Cheshire Home at 177 Agege Motor Road, Mushin, Lagos, housing eight children; the Oluyole Cheshire Home, P.O.B. 1425, Ibadan, which houses eleven children; the Cheshire Home in Enugu, and the Obiomo Cheshire Home, 6 Onwenu Street, Port Harcourt. The operation of the latter two homes was discontinued during the civil hostilities in 1968.

The Child Care and Treatment Home, Surelere, Lagos, was established in 1962 and houses 22 severely handicapped residents with varying disabilities. The Home is supported by voluntary donations raised through the Women's Voluntary Organization. Some physical therapy and educational instruction is available. Another Child Treatment and Placement Home, 50 Apesin Street, Idi Araba, Mushin, Lagos, was opened in 1965. Nine severely handicapped children reside in this home, which is run by a volunteer.

Organizations

The Nigerian Society of Physiotherapy was organized in 1959 at the University College Hospital in Ibadan. By 1968, it had 31 members, all of whom were qualified physical therapists, and was accepted for membership in the World Confederation for Physical Therapy.

The Nigerian Federation of Ex-Servicemen Association, c/o Ministry of Trade and Industry, Ibadan, has been active in seeking improved rehabilitation programs for the more than 10,000 disabled veterans in the country. The Federation is a member of the World Veteran's Federation.

Training Programs

The School of Physiotherapy, University College Hospital, Ibadan, was established in 1964 with the support of a grant from the National Fund for Research into Poliomyelitis and Other Crippling Diseases (U.K.). The first trainees were admitted in 1966. A three year B.Sc. degree course in physical therapy is offered. Training of assistant physical therapists was discontinued in 1960. Only a small number of students are trained in each session. During a recent session, three students were reported to be in training. The Federal Government is considering plans to develop a second school in Lagos.

Seminars and Conferences

The First Seminar on Physiotherapy was held at the University of Lagos, April 1966 by the Nigerian Society of Physiotherapy.

SPEECH AND HEARING DISORDERS

Programs with Government Support

The School for the Deaf, Surulere, Lagos, is supported by the government and voluntary societies. It provides services to 40 boarding and 40 day students. In Ibadan, the School for the Deaf (P.O.B. 808) provides primary schooling to 60 children. Several teachers are qualified in special education. Plans are being made to start a vocational training program in this school which also receives both government and voluntary support.

Programs with International Support

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Programs with Voluntary Support

The Home for the Young Deaf, P.O.B. 822, Ibadan, houses 20 children who receive board, lodging and some schooling.

Organizations

The Council for Education and Welfare of the Deaf in Africa, P.O.B. 808, Ibadan, is affiliated with the World Federation of the Deaf (WFD). The Council also maintains an affiliation with the Ghana Society for the Deaf in Africa. The Committee for the Care of the Deaf and Dumb can be reached c/o Welfare Division, Federal Ministry of Labour, 14, Market Street, Lagos.

Training Programs

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Seminars and Conferences

The First International Conference on Vocational Rehabilitation of the Deaf in Africa was sponsored by the WFD and the Council for Education and Welfare of the Deaf in Africa in mid-1966 in Ethiopia.

BLINDNESS

It has been estimated that 250,000 to 300,000 people in Nigeria are blind. At least 10% of this group is believed to be children.

Programs with Government Support

A Mobile Eye Clinic in Maidugiri (Northern Region) established to help prevent blindness has continued to operate although drugs and equipment have been insufficient. The Farmcraft Centre/Workshop, operated by the Ministry of Labour in this area has progressed in developing products from local materials. Other such centers, however, have only been able to recruit one-third of the trainees that they are equipped to handle. In the Ikeja, Lagos Center, a one year course can be offered to 50 men although there are generally a much smaller number of trainees. A poultry farm was established in this center with assistance from the U.K. Rotary Club. Training centers have also been reported in Ogbomosho (Western Region), Kaduna (Northern Region) and Nnewi.

The Pacelli School for the Blind, Ajao Road, Surulere, Lagos, is supported by the Ministry of Education and is staffed by a Catholic Mission. Primary education is available for the 64 students who board at the school. The students range in age from 3 to 16 years of age.

Programs with International Support

The Royal Commonwealth Society for the Blind has assisted in the establishment of open integrated education schemes for the blind. In 1962, the Society initiated its first experimental scheme in Nigeria in Katsina (Northern Region) and later expanded the program to include the Western Region. In 1966, the Western Region Ministry of Education assumed responsibility for the program. By 1969, approximately 200 blind children were enrolled in more than 100 schools and were being supervised by itinerant teachers. Eighteen children had progressed to secondary education and a braille printing press was being established. The Society planned to undertake construction of a Rural Training Centre in Zaria in 1968 with support from the FAO Freedom from Hunger Committee.

See Also:
American Foundation for Overseas Blind.
U.K. Rotary Club

Listed Under:
Nigerian National Advisory Council for the Blind.
Ikeja Farmcraft Centre

Programs with Voluntary Support

The Vocational Training Centre at Oshodi is supported by the Nigerian Society for the Blind. Courses available for both men and women include Braille, typing, telephone operation, crafts, and home economics. The capacity for 40 trainees has never been fully utilized.

See Also:
Oji River Settlement

Listed Under:
LEPROSY: Programs with Government Support.

Organizations

The Nigerian National Advisory Council for the Blind, P.O.B. 2145, Lagos, is an integral part of the Federal Ministry of Labour. It is composed of government and voluntary organization representatives and is responsible for the coordination of activities for the welfare of the blind throughout the nation. The American Foundation for Overseas Blind provided a study tour for the Director of the National Council to the United States in 1964. The Federal Nigerian Society for the Blind, P.O.B. 2225, Lagos, is supported by both the government and private groups. The Society recruits the blind for rehabilitation programs

from all over the country. Regional organizations conduct their own projects. The North Nigeria Society for the Blind is located at P. Bag, Kaduna (Northern Region).

Training Programs

Approximately 50 teachers were trained in conjunction with the Royal Commonwealth Society for the Blind open education scheme program.

Seminars and Conferences

The First African Conference on Work for the Blind was sponsored by the National Advisory Council for the Blind, January 17-22, 1966, in Lagos. Participants from 15 African nations and 7 international agencies attended the Conference. Resolutions were formulated to stimulate increased facilities for the blind and the prevention of further blindness. The Conference was also sponsored by the Royal Commonwealth Society for the Blind, the World Council for the Welfare of the Blind, and the Royal National Institute for the Blind of Great Britain.

MENTAL ILLNESS AND RETARDATION

Programs with Government Support

The Child Guidance Clinic, Lagos, established in 1964 by a voluntary agency, is now sponsored by the Ministry of Education. Two psychologists, one psychiatrist, and social workers staff this facility which provides evaluations, counseling, and educational instruction for the 24 mentally retarded and mentally ill children in attendance.

The Ministry of Health administers the Mental Hospital, Yaba, Lagos, which has a small well organized occupational therapy department staffed by one qualified occupational therapist and one assistant. Local materials are used in department activities to produce marketable products. The income from their sale is returned to the government in payment of the financial support loaned to the department. The 150-bed Aro Mental Hospital with its short-term patients and the 400-bed Lantoro Hospital with chronic patients, located near Abeokuta, both have occupational therapy departments. Two qualified occupational therapists who use local materials in their programs staff the Aro department and another occupational therapist is assigned to the Lantoro department. The physical therapist from Abeokuta Hospital provides part-time treatment for both institutions.

Programs with International Support

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Programs with Voluntary Support

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Organizations

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Training Programs

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Seminars and Conferences

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LEPROSY

In 1964 it was estimated that there were between 700,000 and 800,000 leprosy patients in the Northern Region alone. An additional 40,000 to 70,000 new cases were registered each year. Less than half of these patients, or 330,000 people, were under treatment in the more than 1,700 clinics and out-patient centers available. A total of 3,000 new clinics were reported to be needed. However, only 100 new clinics were being established in the area each year.

Programs with Government Support

The government operates a leprosy control program in which leprosy specialists are responsible for each region. Medical superintendents oversee the work in each province while paramedical inspectors supervise from twenty to forty clinics. A paramedical leprosy attendant maintains each four or five clinics. Various missions maintain residential leprosaria for each province. UNICEF has supported the development of this control program in conjunction with rural health center extension since 1954 by donating drugs and equipment. The WHO has also assisted in these programs. Leprosy treatment will be included in all rural health units and the facilities of residential leprosaria such as the Garkida Leprosarium may be used for training additional health service workers.

The Director of the Garkida Leprosarium also serves as the government's provincial leprologist in a portion of the Northern Region. He visits approximately 160 clinics with 10,000 patients in the area.

The Iberekodo Leprosy Settlement in the Western Region is supported by the government of the Western Region and voluntary agencies including the Leprosy Relief Association of Great Britain and the American Catholic Relief Association. Housing, treatment, and vocational training in agriculture are provided for 200 men and women in the settlement.

The Oji River Settlement in the Eastern Region was begun in 1936 with support from the Church Missionary Society. Thirty years later nearly 30,000 patients had been treated through the Settlement and its clinics. Medical supervision of the program was transferred to the government of Nigeria in 1966. In 1964, the Settlement received a grant from the Emmaus Suisse to establish an agricultural re-settlement scheme. Trainees between twenty and fifty years of age are selected for the program and receive stipends provided by the Christian Council of Nigeria. Four instructors are on the staff. An additional 87 government clinics are located throughout the Oji River area.

Programs with International Support

The Garkida Leprosarium near Jos (Northern Region)is supported by the American Leprosy Missions (ALM). It serves 489 resident patients and approximately 800 additional patients at five outlying clinics. The ALM also helps to support the Sudan United Mission Provincial Leprosarium, Mongu (Northern Region) which is under the direction of the Sudan Interior Mission Leprosy Service. The staff of this leprosarium also supervises 21 government clinics.

The Church Mission Society of England maintains a large center in Zaria (Northern Region) which includes a leprosarium. The British Leprosy Relief Association also supports this program and the American Leprosy Missions has considered assisting the center in expanding its training facilities for paramedical personnel.

It has been reported that many leprosy treatment centers in the Eastern Region were destroyed during the hostilities following 1967. The center near Umuahia was rebuilt for approximately 100 patients.

See Also:	Listed Under:
UNICEF, WHO	Programs with Government Support
Emmaus Suisse	Oji River Settlement
Leprosy Relief Association of Great Britain	Iberekodo Leprosy Settlement
American Catholic Relief Association	Iberekodo Leprosy Settlement

Programs with Voluntary Support

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Organizations

The Nigerian Leprosy Relief Association, 4 Denton Street, Lagos.

Training Programs

A government supported leprosy worker training center is maintained in Kaduna (Northern Region). This center does not include treatment facilities.

Seminars and Conferences

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SUMMARY

	Rehabilitation Facilities	Institutions Reporting Capacity	Approximate # of patients per yr.
Orthopedic and Neurological Disorders	21	8	201
Speech and Hearing Disorders	3	3	160
Blindness	8	4	354
Mental Illness and Retardation	4	3	574
Leprosy	Clinics (Northern) - 1700 Leprosaria - 6	Clinics - 1700 Leprosaria - 3	Clinics - 330,000 Leprosaria - 789
	42	21	2018

	Training Programs	Capacity - Students per year
Physical Therapy	1	less than 10
Occupational Therapy		
Speech and Hearing		
Special Education-Teachers of the Blind	1	50
Vocational Rehabilitation		
Prosthetic and Orthotic		
Leprosy Workers	1	-

	Institutions Reporting Services	Institutions Reporting Personnel	Personnel
Prosthetists and orthotists	3	2	5
Prosthetic and orthotic technicians	1	1	30
*Physical therapists	9	7	22
Physical therapy aides and auxiliaries	2	2	8
Occupational therapists	5	5	8
Occupational therapy aids and auxiliaries	2	2	3
Speech and hearing therapists	-	-	-
Special education teachers	7	2	54
Rehabilitation Social Workers	2	1	2
Vocational Rehabilitation counselors	-	-	-
Physiatrists	2	1	1
Psychiatrists and psychologists	1	1	3
TOTAL	34	24	136

* This figure does not equal the total number of 31 qualified physical therapists reported by the Nigerian Society of Physiotherapy.

Location of Rehabilitation Facilities	Institutions
Territory of Lagos	15
Northern Region (Kano, Katsina, Kadura, Jos, Maidugeri, Mongu)	8
Western Region (Ibadan, Abeokuta, Iberekodo, Ogbomosho)	12
Eastern Region (Enugu, Port Harcourt, Oji River, Aboh, Atta, Umuahia)	7
Mid-Western Region	0
TOTAL	42

CONCLUSIONS

There is a severe shortage of rehabilitation facilities for all types of disabilities in Nigeria. Available services can assist less than one-tenth of one percent of the more than two and one-half million people in this country who, it may be conservatively estimated, have physical and mental disabilities. According to government statistics, fewer than 1,500 children and adults with disabling conditions ranging from blindness and deafness to crippling disorders received some form of educational or rehabilitation assistance in 1969 although estimates of the number of persons in specific disability groups ranged from 10,000 disabled veterans to more than 250,000 blind individuals. While medical services have been extended to almost one-half of the nation's 700,000 leprosy patients, the extent to which these patients may receive rehabilitation services is not known.

The minimal amount of trained personnel in certain rehabilitation-related fields, the total lack of personnel in other fields, and the almost complete absence of training programs in rehabilitation-related subjects within the country may be contributing both to the shortage of facilities and the incomplete utilization of some of those facilities already in existence.

Most of the available rehabilitation services are located within or near the urban centers of Lagos and Ibadan in the western section of the country although the bulk of the population does not live within this area.

Little is know about the extent and etiology of disability in Nigeria. Poliomyelitis appears to be endemic and is reported to be a significant cause of disability each year. Preliminary mass vaccination attempts against this disease in a selected area have not as yet proven to be effective.

While the Federal and state governments of Nigeria have given financial support to a number of facilities and centers, many of the existing efforts are from the private sector. A large proportion of these receive or have received assistance from international and national non-governmental agencies and occasionally, upon the request of the government, experts have been supplied by the United Nations or its specialized agencies. In general, international assistance for the development of rehabilitation services throughout the country has been limited. It has been given sporadically with no comprehensive or long-range planning in view.

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APPENDIX E - MAJOR REHABILITATION SERVICES IN THE PHILIPPINES

INTRODUCTION

The Republic of the Philippines is composed of 7,100 islands stretching across the south west portion of the Pacific Ocean to the south of China, north of Indonesia and east of Malaysia. Only 462 of these islands have a land area larger than one square mile and 11 islands contain the bulk of the nation's 115,600 square land area. The Philippines is almost equal in land area to Italy. The major cities, Manila and Quezon City, and their surrounding areasPasay City, Caloocan, San Juan, Makati, Paranque, and Mandaluyong, are all located on the largest island, Luzon. Most of the Philippines 35 million people live on the island of Luzon and three of the smaller islands. Railroads and motorable roads connect the towns in southern Luzon. Motorable roads are also available in most portions of the major islands.

Principal economic activities include agriculture, livestock breeding and fishing. In 1967, the Philippines became self-sufficient in rice production. Forests which cover almost one-half of the land area provide lumber, oils, resins and other products. The islands are also rich in a variety of mineral resources.

Primary and secondary education is free in the Philippines public school system. Higher education is available in the University of the Philippines, which is state-owned, and in an additional 14 private universities, 341 colleges, 484 vocational schools and eight vocational colleges.

Although a bed capacity of more than 40,000 beds was available in the 329 government hospitals and 208 private hospitals located throughout the country in 1960, it is reported that an acute shortage of hospital space is prevalent. In 1965, there was approximately one doctor for each 1,330 people.

ORTHOPEDIC AND NEUROLOGICAL DISORDERS

It may be conservatively estimated,on the basis of figures available for the cerebral palsied and disabled veteran population,that there are more than 200,000 disabled children and adults with orthopedic and/or neurological disorders in the Philippines.

Programs with Government Support

The National Orthopedic Hospital, Banawe, Quezon City, is a government hospital supervised by the Ministry of Health that provides free care and out-patient treatment for traumatic and orthopedic cases. It was established in 1945 with assistance from the U.S. Army, and is maintained under the direction of the Department of Health. In 1962,

the hospital was moved to its present new quarters. Although the hospital has a 400 bed capacity, a much greater number of in-patients are being accommodated. About 14000 out-patients can also receive treatment within this facility. Physical therapy, occupational therapy, social services, special education, limited vocational rehabilitation, and prosthetic and orthotic services are all available. The United Nations provided equipment and technical supplies for the occupational therapy and vocational rehabilitation sections. The Prosthetic and Surgical Appliances Center was begun in 1961 with assistance from Australia under the Colombo Plan. Equipment, technical assistance, and on-the-job training for technicians were provided during the Center's five-year development period. Overseas training fellowships were also made available to one resident and the chief prosthetist by the International Cooperation Administration. A United Nations fellowship for one prosthetist to attend a United Nations Training seminar was provided in 1968. The World Rehabilitation Fund (WRF) also provided short-term training fellowships for a prosthetist and staff member from the Center. The United Nations and the World Veterans Federation (WVF) provided physical therapy experts to work in the hospital and trained physical therapy technicians. In 1961, with support from the World Health Organization (WHO), the training programs for physical therapists and occupational therapists were expanded. Resident physicians and nurses also received training in rehabilitation within the hospital.

Two of the other hospitals under the direction of the Ministry of Health which have rehabilitation departments are the Philippines General Hospital with a 30 bed orthopedic patient capacity, and San Lazaro Hospital for Communicable Diseases, with its separate acute polio ward and physical therapy service. A Clinical Teaching Center in Physical Therapy has been established in the Philippines General Hospital in cooperation with the School of Allied Medical Professions. The Rehabilitation Medicine Department in this hospital is directed by a physiatrist.

To meet the needs of the estimated 100,000 disabled veterans, the government of the Philippines maintains rehabilitation services in its military hospitals. The Department of National Defense administers the Veteran's Memorial Hospital, Hilaga Avenue, Quezon City, in cooperation with the U.S. Veteran's Administration. Services including physical therapy, occupational therapy, social service, and limited vocational rehabilitation are provided through the Department of Physical Medicine and Rehabilitation. There were two physical therapists and eight physical therapy aides on the staff in 1963. The physiatrist in charge of the Department and one physical therapist were trained overseas under the sponsorship of the WRF. The hospital also has a 39 bed orthopedic service. The V. Luna General Hospital, Kamias Road, Quezon City, is for use by members of the Armed Forces. Orthopedic cases are allotted 65 beds. The Rehabilitation Department maintained under the direction of a trained physiatrist, offers physical therapy,

occupational therapy, and speech therapy. There are two trained physical therapists on the staff. They are assisted by masseurs and physical therapy assistants. A brace and prosthetics shop is also operated.

In 1954, legislation was passed authorizing the Office of Vocational Rehabilitation of the Social Welfare Administration to supervise the adjustment, vocational training, and placement of the handicapped. The National Vocational Training Center was then established under the auspices of this Office. The Social Welfare Administration was recognized as a separate government department with its own budget in 1968. The United Nations Children's Fund (UNICEF) has been supporting programs for children and youth through this Department. An amendment to the 1954 law provided for the establishment of nine regional vocational rehabilitation training centers. Programs are being developed in Dagupan, Luzon and Zamboanga, Mindanao. An instructor from the Dagupan center was awarded a fellowship by the American Foundation for Overseas Blind (AFOB) in 1968 to attend a training course in mobility instruction.

A National Council for Rehabilitation was created in 1959. The National Council is responsible for formulating national policies and standardizing activities related to rehabilitation. It is composed of fifteen members drawn from the government and various medical, educational, scientific, industrial, labor, and civic groups and appointed by the President. Due to administrative problems, the Council has not been able to function effectively.

The National Vocational Training Center, Bugos Street, Quezon City, is a day center providing training for approximately 100, handicapped people at a time. Its five divisions are the: Administrative Section, Medical Section, Social Welfare Section, Vocational Section, and the Sheltered Workshop. General education instruction and braille instruction are provided. Training is available in a variety of occupations including clerical work, tailoring, telephone operation, poultry breeding, and market gardening. A voluntary group called the Community Rehabilitation Action Group has helped to secure employment and on-the-job training. This group also conducts fund raising activities. Thirty handicapped people are employed in the Sheltered Workshop doing clothing renovation and contract work. Training in sheltered workshop management was provided to one administrator with support from the Goodwill Industries of America. A small tailoring section and basket manufacturing section are also available. The Research Study Center of the Department of Social Welfare screens all clients and evaluates each case periodically. There are nine instructors and seven assistants on the staff. Technicians from the Center have received overseas training with assistance from the Colombo Plan, the United Nations, and the International Labor

Organization (ILO). Consultative services and equipment were provided by the AFOB during the Center's first three years of operation. The ILO began to assist in the development of the program in 1959 and then assigned a Vocational Guidance Officer to the Center in 1960. Proceeds from the Philippines Charity Sweepstakes have been made available to this project. Other interested organizations including U.S. Naval Bases have provided necessary materials. Estimates of the number of disabled persons admitted for services and assistance at the Center since its establishment range from 500 to more than 1,500 people. More than 150 people are currently reported to be processed through the Center per year.

The Elsie Gaches Village National Center for Disabled Children, Alavang, Rizal, is administered by the Department of Social Welfare's Office of Child Welfare with assistance from UNICEF. A total of 120 severely handicapped children between 3 and 16 years of age may be accommodated at the center. Children with handicaps including cerebral palsy, mental retardation, blindness, deafness, and orthopedic disabilities are accepted. Activities of daily living and school subjects are taught. The supervisor of the staff is a trained social worker and an orthopedic surgeon visits the program. The Office of Child Welfare cooperates with the Center by providing consultations with its staff members.

The Bureau of Workmen's Compensation of the Department of Labor created a "Screening Committee on Rehabilitation of Crippled Men in Industry" in 1958. Funds to assist 54 handicapped workers were set aside and were used for expenses such as prostheses, vocational training, and transportation. In 1964, the Workmen's Compensation Act was amended to require that all employers provide benefits for their disabled employees.

Programs with International Support

The San Pablo Rehabilitation Center, San Pablo City, was established in 1961 and is located within the San Pablo Community Hospital, fifteen miles north of Manila. It is administered by a non-profit foundation which is affiliated with the Philippines Foundation for Rehabilitation of the Disabled. It has received support from the Franklin Baker Company, a subsidiary of the General Foods Corporation of the United States. The WRF assists in equipping, staffing, and operating this center. The center is under the direction of a physiatrist and offers physical therapy, and occupational therapy for orthopedically handicapped children and adults. Artificial limbs and braces are produced in cooperation with the Prosthetics Center at the National Orthopedic Hospital. Nurses and prosthetists have received training at the Center. Nine people were initially on the staff of this project. More than 500 people have been treated per year at the center. A large percentage of these patients come from surrounding rural areas.

The World Rehabilitation Fund has been responsible for training twelve Filipino physicians in Physical Medicine and has supported the training of paramedical personnel as well. In 1968, the Fund again provided fellowships for long-term training in physiatry and short-term training in prosthetics.

See Also:	Listed Under:
Colombo Plan, WVF, United Nations International Cooperation Administration	The National Orthopedic Hospital
UNICEF	Office of Vocational Rehabilitation
AFOB	Dagupan Vocational Training Center
AFOB, ILO, Colombo Plan	National Vocational Training Center
UNICEF	Elsie Gaches Village National Center for Disabled Children
UNICEF, WHO, United States Peace Corps, CARE	The School for Allied Medical Professions Elks Cerebral Palsy Center

Programs with Voluntary Support

The Elks Cerebral Palsy Center, Mental Hospital Compound, Mandaluyong, Rizal, is located on land donated by the Government. The Elks and other voluntary supporters have been sponsoring this program since its establishment in 1957. Some assistance has also been given by CARE. The Center is a member of the World Commission for Cerebral Palsy of the ISRD. It is estimated that there were 50,000 children and adults with cerebral palsy in 1968. A total of 4,500 of these people have been assisted in the Center since it opened. About 100 cerebral palsied children receive educational assistance and medical services in the Center's day program. Prosthetic devices are made for the children at the National Orthopedic Hospital. The staff of 32 people includes two occupational therapists, several occupational therapy assistants, two physical therapists, physical therapy aides, a speech therapist, a head teacher, and two assistant teachers. A medical director and his assistants are in charge of the program. Several of the staff members have been trained abroad. Two Peace Corps Volunteer occupational therapists and one Peace Corps Volunteer speech therapist have served on the staff. In-service training for medical and paramedical personnel is a part of the Center's program. Plans to construct a new building in a different location are being formed.

The Elks Cerebral Palsy Western Visayas Branch Clinic, Iloilo City, was operated as a day center for cerebral palsied children and adults until its closure in 1968. A total of 247 patients received physical therapy, occupational therapy, social services, and special education at this Center. In 1966 the Eastern Visayas Branch Clinic was opened in Cebu City. By 1968, 120 patients had been treated there.

The Philippines Band of Mercy, East Avenue, Quezon City, is a private non-profit organization established in 1947 which assists people who are in need of medical assistance. The Band provides temporary lodging for patients from remote parts of the country and pays for their medical bills as well as for their orthopedic and prosthetic appliances. Some government subsidy is available to assist the Band in its work. Approximately 20 patients can be accommodated.

Private hospitals which contain rehabilitation and orthopedic services are: Our Lady of Lourdes Hospital, Manila; University of Santo Tomas Hospital, Manila; Hospital de San Juan de Dios, Pasay City; St. Lukes Hospital, Quezon City, Manila; Sanitarium and Hospital, Pasay City; Uerm Memorial Medical Center, Quezon City; and the Mary Johnson Hospital, Manila. In addition private clinics such as the De Los Santos Clinic, Quezon City, with its 30 bed capacity, and the Gonzalez Orthopedic Clinic, Manila, with a 10 bed capacity offer rehabilitation services.

Organizations

The Philippines Association of Compensation Medicine, c/o Workmen's Compensation Division, Department of Labor, Manila, was originally called the Philippines Association on Rating of Physical Impairment and Rehabilitation (PAROPIR). The association has sponsored conferences and symposiums to promote concern for the handicapped. The association presently provides tools to disabled persons to enable them to be self-employed. Itsmembers represent labor, industry, and professional fields.

The Philippines Association of Social Workers encourages rehabilitation program development and many of its members are actively engaged in rehabilitation work.

The Philippines Foundation for the Rehabilitation of the Disabled, Inc., 1729, J.P. Laurel Street, Manila, was founded in 1949 and in 1956 became affiliated with the ISRD. This voluntary organization maintains a program of public information, promotes legislation for the handicapped, and assists in coordinating rehabilitation activities.

The Philippines Medical Association, 1850 Taft Avenue, Manila, has a Committee on Rehabilitation.

The Philippines Society of Physical Medicine and Rehabilitation, c/o the V.P. Luna General Hospital is composed of physiatrists. Regular meetings and conferences are held on this speciality.

The Philippines Physical Therapy Association, 8876 (1828) Sampaloc Avenue, San Antonia Village, Makati, Rizal, was established in 1946 and has a total membership of 27 graduate physical therapists and 8 physical therapy technicians. The Association was granted provisional membership in the World Confederation for Physical Therapy in 1967.

The Philippines Tuberculosis Society, Quezon City, supports programs to combat the effects of tuberculosis. It is estimated that 10% of the population is affected by this disease.

Training Programs

The School of Allied Medical Professions (SAMP), College of Medicine, University of the Philippines, National Orthopedic Hospital, Manila, was established in 1962 and is composed of a School of Physical Therapy and a School of Occupational Therapy. The graduates of the SAMP program receive Bachelor Degrees. The occupational therapy program received accreditation from the World Federation of Occupational Therapists in 1962. The physical therapy program is being accredited by the World Confederation for Physical Therapy. Thirty-two students were enrolled in the program in 1966 and a capacity for 25 new students yearly was available. By 1966, 26 physical therapists had graduated. The two occupational therapy graduates are lecturers in the School of Occupational Therapy which has 16 trainees registered. There are only three speech therapists in the country. As they all were trained overseas, it is being proposed that training in speech and hearing therapy also be included with the SAMP program.

This government supported program was developed with assistance from international organizations. UNICEF provided physical therapy equipment, supplies and stipends for two years of training for nurses from various provinces. Additional equipment and supplies were provided from the Colombo Plan. A United Nations expert posted in the National Orthopedic Hospital initiated the physical therapy training program in 1959. A WHO advisor in physical therapy was then assigned to the project from 1961 until 1965. A WHO advisor in occupational therapy was present from 1962 until 1966. In 1968, a Colombo Plan physical therapy expert began a two-year assignment in SAMP and a Colombo Plan occupational therapist was assigned to the program in 1970. One trainee from the program received WHO sponsorship to participate in a World Confederation for

Physical Therapy teacher training course.

Seminars and Conferences

The Second Pan-Pacific Conference on Rehabilitation, sponsored by the Philippines Foundation for Rehabilitation of the Disabled and the ISRD, was held in Manila from December 3-7, 1962. The theme was "National Programs for Rehabilitation--A Challenge in the Pacific." A two-week prosthetics course and seminar on special education and vocational rehabilitation preceded the conference. Of the 440 delegates attending the conference, 120 were from more than 15 overseas countries.

The Asian Regional Seminar on Vocational Rehabilitation sponsored by the Philippines Government and ILO was held in Manila in November, 1960. Representatives from ILO, the government of the Philippines and the ISRD, participated in the seminar along with 25 delegates from 12 Asian countries.

The International Conference on Social Welfare will be held in Manila from September 6-12, 1970 with support from the International Council on Social Welfare.

The Third Congress of the Western Pacific Orthopedic Association will be held in Manila in cooperation with the National Orthopedic Hospital from April 2-9, 1970.

SPEECH AND HEARING DISORDERS

In 1962, there were an estimated 111,000 people in the Philippines with speech and hearing impairments. Approximately 20,000 of the people in this group may be classified as deaf.

Programs with Government Support

The School for the Deaf and Blind, 2620 F.B. Harrison, Pasay City, Rizal, was founded in 1907 and resumed operation in 1946. The school is administered and supported by the Special Education Section of the Department of Education and also receives support from voluntary organizations. Approximately 60 of the 406 children enrolled in the program reside in the school dormitory. Although blind students were initially enrolled in the school, the majority of the students currently enrolled are deaf. Instruction in speech, lip reading, and language and elementary and secondary grade subjects is provided. There is a small vocational program involving tailoring, barbering, wood-working, and home economics. All of the teachers in the school are education

college graduates who have received additional training in special education. A number of teachers have also received specialized training overseas. A total of 76 people are on the staff.

See Also:
NEUROLOGICAL AND ORTHOPEDIC DISORDERS
National Vocational Training Center
Elsie Gaches Village National Center for Disabled Children

Programs with International Support

United States Peace Corps Volunteers trained in speech therapy and special education have assisted in the development of programs for the hearing impaired.

In 1969, CARE contributed four braille writers to the School for the Deaf and Blind.

Programs with Voluntary Support

The Philippines Association of the Deaf, Fernando Yap, 328 Cavelleros Street, Binondo, Manila, is supported by the Community Chest of Manila. The Association operates a vending program and a day nursery for the children of working mothers. It has approximately 200 members.

Organizations

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Training Programs

From 1956 until 1960, teachers from various parts of the Philippines received training at the School for the Deaf and Blind. Presently the Philippines Normal College, a government institution, offers courses in special education which deal with the problems of the deaf and the blind. Five private universities, the University of the Philippines, the Philippines Women's University and the Arellano University offer basic special education courses. Provision for special education teacher training is being included within the Department of Education's ten-year teacher training plan.

Seminars and Conferences

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BLINDNESS

There were an estimated 124,000 blind persons in the Philippines in 1962.

Programs with Government Support

Integrated programs for the blind administered by the Special Education Section of the Department of Education are reported to be in operation in 50 schools. By 1968, more than 400 blind children were enrolled in regular schools through these programs. Legislation authorizing integrated programs was approved in 1963.

See also:

ORTHOPEDIC AND NEUROLOGICAL DISORDERS
National Vocational Training Center

Programs with International Support

The American Foundation for Overseas Blind has assisted in the development of integrated programs for the blind by providing teaching materials and supplies to those schools which offer a basic curriculum for blind and visually handicapped children. The AFOB also provided a consultant in vocational training to the National Vocational Training Center and has helped to survey special education in Manila.

Programs with Voluntary Support

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Organizations

Various organizations for the blind have been formed throughout the Philippines. Attempts to federate these groups into a national organization have not succeeded. Thirteen fund-raising organizations for the blind are registered with the Social Welfare Administration. They receive some supervision and support in developing their programs. In addition, a Lions Club group formed the Northern Luzon Blind Association located in Baguio City.

Training Programs

Five teacher preparation courses were concluded by 1968, and a sixth course was begun with continuing professional guidance from the AFOB.

See also:
DEAFNESS, Training Programs

Seminars and Conferences

With support from the AFOB and the Royal Commonwealth Society for the Blind, the Third Asian Conference on Work for the Blind was held in Manila from August 26-31, 1968.

MENTAL ILLNESS AND RETARDATION

An estimated 3% of the population of the Philippines or almost one million people are mentally retarded. Estimates of an additional 35,000 mentally defective or insane people and 155,000 socially or emotionally handicapped people were reported in 1962.

Programs with Government Support

The National Hospital, Mandaluyong, Rizal, is administered by the Department of Health and accommodates about 5,000 patients even though it only has a 2,000 patient capacity. This facility provides treatment and confinement for the mentally ill. Physical therapy, occupational therapy, and social services are available.

Programs with International Support

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Programs with Voluntary Support

The Special Child Study Center,Inc. 4618 Old Sta Mesa, Manila, offers services for mentally retarded children and adolescents. Diagnostic evaluation, vocational training, and parent counseling are provided. About 90 children attend this program. The center is an affiliated member of the International League of Societies for the Mentally Handicapped. There are at least five other private schools which have programs for the retarded.

Organizations

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Training Programs

Post-graduate training in the education of the mentally retarded is offered at two universities.

See also:
DEAFNESS, Rehabilitation Training Programs

Seminars and Conferences

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LEPROSY

It was estimated that in 1964 there were 30,000 people affected by leprosy in the Philippines.

Programs with Government Support

The Bureau of Disease Control of the Ministry of Health operates traveling and static skin clinics as a part of its leprosy control activities. An estimated 22,000 patients were to be under treatment by 1968. UNICEF has assisted in these programs by supplying equipment, training grants, and transport facilities. Leprosy sanatoria administered by the department are located in: Culion, Palawan; Caloocan City, Rizal; Mandawe, Cebu; Western Visayas, Iloilo; Cabusal, Camarines Sur; Nuling, Cotabato; Zamboanga City, Mindanao; Jolo, Zulu. More than 8,000 patients can be confined and treated in these centers. Some rehabilitation services including physical therapy, occupational therapy, social service, and vocational rehabilitation are available.

Programs with International Support

The Skin Clinic and Sanitarium in Cebu was established by the Leonard Wood Memorial and was later given to the government.

Approximately 550 patients are treated in the Center. The Leonard Wood Memorial has continued to conduct research projects in this facility in cooperation with research institutes in the United States.

See also:
UNICEF, Programs with Government Support

Programs with Voluntary Support

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Organizations

The Friends of the Lepers, Inc. carries out a program of rehabilitation as well as public education.

Training Programs

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Seminars and Conferences

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SUMMARY

	Rehabilitation Facilities	Institutions Reporting Capacity	Approximate # of patients per year
Neurological and Orthopedic Disorders	19	12	15,500
Blindness	50	50	400
Speech & Hearing	1	1	400
Mental Retardation	5	1	100
Mental Illness	1	1	5,000
*Leprosy	8	8	8,000
TOTAL	84	73	29,400

*This figure does not include the number of patients assisted through leprosy control activities.

	Training Programs	Students per year
Physical therapy	1	25
Occupational therapy	1	16
Speech and hearing therapist	-	-
Special education	10	-
Vocational rehabilitation counselling	-	-

Location of Rehabilitation Facilities	Institutions
Quezon City, Luzon	8
Rizal District (Pasay City-Mandaluyong) Luzon	8
Manila, Luzon	8
Northern Luzon	2
Eastern Visayas (CebuCity)	2
Western Visayas (Iloilo)	1
Mindanao (Zamboanga, Cotaboto)	3
Other Islands	3
TOTAL	35

	Institutions Reporting Services	Institutions Reporting Personnel	Personnel
Prosthetists and orthotists			1
Prosthetic and orthotic technicians	2	1	1
*Physical therapists		3	6
Physical therapy aides and auxiliaries	7	1	8
Occupational therapists	6	1	2
Occupational therapy aides			3
Speech and hearing therapists	2	1	1
**Special education teachers	5	2	4
Social workers	6	1	1
Vocational counselors	4	1	9
***Physiatrists	6	5	5
TOTAL	36	16	41

*This figure does not equal the total number of 27 trained physical therapists and eight physical therapy technicians reported by the Philippines Physical Therapy Association.

**This figure does not include teachers in programs for the blind reported to be in operation in 50 schools.

***This figure is less than the total number of physiatrists which the WRF has reported training.

CONCLUSIONS

On the basis of the information about rehabilitation services in the Philippines included in this report it may be estimated that a maximum of 50,000 handicapped people, or three percent of the total estimated disabled population of one and three quarter million people, have received some type of rehabilitation service. This estimate is based on the assumption that the statistics compiled in the report reasonably reflect the capacity of available rehabilitation services. It also assumes that the existent services are being fully utilized.

Patients with orthopedic and/or neurological disorders have received the most rehabilitation services. Approximately ten percent of the disabled in this group have been assisted at some time. It has been planned that leprosy control activities operated through sanitoria, mobile clinics, and static units would be expanded to serve almost 75% of all leprosy patients in the Philippines by 1968. As a part of these activities, leprosy patients may also receive some rehabilitation services. Less than one percent of all the blind, deaf, mentally ill, and mentally retarded people in the Philippines have received any type of rehabilitation service. Since more than two-thirds of the rehabilitation facilities are located in the major urban area on Luzon, it must also be assumed that only the tenth of the national population which lives in this area has reasonable access to rehabilitation programs.

Training facilities are available for several types of rehabilitation personnel; however, an insufficient number of people are being trained to meet the needs of already existing facilities. Training facilities are completely lacking for personnel in other rehabilitation-related fields. While available figures indicate that not all trained personnel are working in established rehabilitation facilities, the number of trained personnel actually providing rehabilitation service is not known.

International support to develop rehabilitation services for the orthopedically and/or neurologically disabled in the Philippines has been considerable. Assistance has been provided in the form of long-term advisors, equipment and supplies, and training fellowships. Important international efforts have also been directed towards leprosy control and the education of the blind. Little assistance has been available for programs for the deaf, mentally ill, and mentally retarded.

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APPENDIX F - PARTICIPANTS IN THE EXPERT MEETING ON ASSESSMENT OF LEVELS OF SERVICE RELATED TO AVAILABLE RESOURCES KILLARNEY, IRELAND, SEPTEMBER 21-24, 1969

Gudmund Harlem, M.D. Chairman	Past President, International Society for Rehabilitation of the Disabled Director, State Rehabilitation Institute, Oslo, Norway
Miss Elizabeth M. Anderson	Research Officer Department of Child Development London University
Jose J. Arvelo, M.D.	Chief, National Rehabilitation Program Division of Sanitary Dermatology Ministry of Health Caracas, Venezuela
Norman E. Cooper	Vocational Rehabilitation Officer International Labour Office
Alvaro Ferrari, M.D.	Professor in Physical Medicine and Rehabilitation Chairman, National Commission for Rehabilitation Uruguay
J.A.E. Gleave	Representative of International Committee on Prosthetics and Orthotics Prosthetic & Orthotic Consultant
Duncan Guthrie, M.A.	Director, National Fund for Research into Crippling Diseases, and Central Council for the Disabled United Kingdom
Aleksander Hulek, Ph.D.	Secretary General Polish Society for Rehabilitation of the Disabled Poland

K.G. Korsah, F.R.C.S.	Orthopaedic Surgeon Orthopaedic Department Korle Bu Hospital Ghana
Esko Kosunen	Chief, Rehabilitation Unit for the Disabled United Nations
Mrs. Helen Love	Physical Therapist Queen Elizabeth II Hospital Maseru, Lesotho
Martin E. McCavitt, Ed.D.	Chief, Division of International Activities Social and Rehabilitation Service Department of Health, Education and Welfare U.S.A.
Miss Joyce Neilson, M.B.E.	Secretary General World Confederation for Physical Therapy
Miss Mary J. Seivwright, Ed.D.	Nurse Adviser International Council of Nurses
Mrs. Verna Spencer	Physical Therapist Association for the Physically Disabled Kenya
Eugene J. Taylor	Secretary-Treasurer World Rehabilitation Fund
Spyros S. Theologos	Director General Institute for Research and Vocational Rehabilitation, and National Foundation for Rehabilitation of the Disabled Athens, Greece
Miss Jean Waterston	World Federation of Occupational Therapists

George Wilson	Secretary, Committee for Rehabilitation of the Disabled in Africa Director, President's Polio Appeal Uganda
J. Yamamoto, M.D.	Medical Officer Organization of Medical Care World Health Organization

Secretariat

Norman Acton	Secretary General International Society for Rehabilitation of the Disabled
Mrs. Dorothy Warms	Deputy Secretary General International Society for Rehabilitation of the Disabled
Mrs. Susan Hammerman	Program Specialist International Society for Rehabilitation of the Disabled

APPENDIX G - PARTICIPANTS IN THE MEETING ON "DEVELOPMENT OF AN INTERNATIONAL REHABILITATION TERMINOLOGY" ISRD ELEVENTH WORLD CONGRESS, DUBLIN, IRELAND, SEPTEMBER 1969

Miss B. Collins	World Federation of Occupational Therapists
Mr. Esko Kosunen	United Nations
Mme H. de Montferrand	Comité National Francais de Liaison pour la Réadaptation des Handicapés
Dr. Eugene Murphy	International Committee on Prosthetics and Orthotics of the International Society for Rehabilitation of the Disabled
Miss M.J. Neilson	World Confederation for Physical Therapy
Mr. N.E. Søndergard	Scandinavian-English Rehabilitation Terminology Project
Mr. N.I. Sundberg	United Nations Educational, Scientific and Cultural Organization
Chairman: Dr. William Usdane	Social and Rehabilitation Service, United States Department of Health, Education and Welfare